# DSG Development Support Group

August 18, 2015

Melanie Hill, Executive Director Tennessee Health Services and Development Agency Andrew Jackson Building, 9<sup>th</sup> Floor 502 Deaderick Street Nashville, TN 37243

RE: CON Application CN1508-030

chen Wellfor

The Endoscopy Center of Knoxville--Relocation and Capacity Reduction Knox County

Dear Mrs. Hill:

This letter requests consent calendar review for the subject application, which was filed on August 14.

The applicant is requesting a change of location for a long-established single-specialty endoscopy ASTC, to a new site within the same county and close to its present location.

The project will reduce procedure room capacity, and its utilization will exceed every applicable guideline. There is no proposed change in ownership composition.

For those reasons, the applicant hopes that the Board will grant consent calendar review, to expedite project completion.

Respectfully,

John Wellborn Consultant

# **Original**

# The Endosocopy Center of Knoxville

CN1508-030

# DSG Development Support Group

August 14, 2015

Melanie Hill, Executive Director Tennessee Health Services and Development Agency Andrew Jackson Building, 9<sup>th</sup> Floor 502 Deaderick Street Nashville, TN 37243

RE:

**CON Application Submittal** 

The Endoscopy Center of Knoxville--Relocation and Capacity Reduction

Knox County

Dear Mrs. Hill:

This letter transmits an original and two copies of the subject application. The affidavit and filing fee are enclosed.

I am the contact person for this project. Please advise me of any additional information you may need. We look forward to working with the Agency on this project.

Respectfully,

John Wellborn

# Team members at Vanderbilt Mortgage and Finance, Inc. receive:

- Access to our state-of-the-art facility,
- Competitive pay and bonus structure,
- Wellness facility and programs,
- Training and Development,
- And much more!!

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No Bidder may withdraw his bid within sixty (60) days after the actual date of the opening thereof.

With this bid, each Bidder must deposit security in the amount of live subject to the condi-tions stated in the instructions to Bidders.

All Bidders must be licensed Contractors and Bidders must be licensed Contractors for as required by the Con-tractors for as required by the Con-tractors of 1916 (TCA Title 62, Chapter 6), No bid will be sealed envertage of the sealed envertage of the sealed envertage of the contractors includes the old provides the told sound information: the Contractor's license number, the date of the told form points of the part of his classification and a quotator's license out on the Bid form provided applying to the pid. All bids must be must be must be contract documents.

The Owner reserves the right to walve any informality and to accept or releat any or all bids.

lou

ACS Document Imaging
Craig Walker, Objectations Manager
Z01 Center Park Drive, Sulte 1120
Rooxville, Tennessee 37922

Upon request the Drawings, and Specifi-cations, may be obtained from the following:

Bids will be received by the Town of Yonore, in the Community Center Street, Yonore The Local Time, on Wednesday, September 2nd, 2015 and then at said time publicly opened and read aloud

Mandatory Pre-Bid meeting will be held at the Town of Vonore, in the Community Center Room above the Library at 613 Church Street, Vonore III, at 19:00 AM, Local Time, on Monday, Anguest 24th, 2015,

womy on macronical and serviced and short period to the macro shall be licensed and insured mance and shall be licensed and insured and shall be licensed and insured to the license and shall be licensed and sha

Pursuant to TCA Sec. 68-11-1607(c)(1): (A) any health care institution wishing to oppose a Certificate of Need spplication must file a written objection with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled, and (B) any other person wishing to oppose the application must file written objection with the person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application of the consideration of the application of the consideration of the application of the consideration of the property of the property of the publication of the consideration of the c

Upon written request by Interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:
Tennessee Health Services and Development Agency
SOS Deaderick Street
Mashville, TN 37243

The anticipated date of Illing the application is on or before August 14, 2015. The contact person for the project is John Wellborn, who may be reached at Development Eupport Group, 4219 Hilsboro Road, Sulte 210, Mashville, TN 37215; (615) 665-2022.

This facility is currently licensed by the Board for Licensing Health Care endoscopy. The relocation will not change the facility's license classification. The project does not contain major medical equipment or initiate or discontine any other health service; and it will not affect any facility's licensed bed complements.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-160 et
Seq., and the Nulse of the Health Services and Development Agency, thist The
Endoscopy Center of ambulatory surgical treatment center), owned by The
Endoscopy Center of Ambulatory surgical treatment centery, owned by The
Endoscopy Center of Knoxville, L.P. (a limited partnership), and managed by
Annoug Corp, (a corporation), intends to bile an application to A center of
Annoug Corp, (a corporation), intends to be publication to a central corp,
Meed to relocate from 801 Wetgarber Road, Suite 100, Knoxville, 10 37950 to
an unaddressed after in the northwest quadrant of the intersection of Middleand and the suite of the sound of the intersection of Middleand the suite of the intersection of Middleand the suite of the sound of the intersection of Middleand the suite of the suite of the sound of the intersection of Middleand an anaddressed after in the northwest good, 500 will be the actual capital cost;
The balance constent of nong-term leases payments which must be included
under COM rules.

This facility is currently licensed by the Board (or Urensing Health Case)

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

Public Notices,

sopiic Notices



# THE ENDOSCOPY CENTER (KNOXVILLE)

# CERTIFICATE OF NEED APPLICATION TO CHANGE LOCATION AND TO REDUCE SURGICAL CAPACITY

**Submitted August 2015** 

#### PART A

#### 1. Name of Facility, Agency, or Institution

The Endoscopy Center		
Name		
Unaddressed site at northwest quadrant o	f the intersection of Mid	dlebrook Pike (TN 169)
and Dowell Springs Boulevard		Knox
Street or Route		County
Knoxville	TN	37909
City	State	Zip Code

#### 2. Contact Person Available for Responses to Questions

John Wellborn	Consultant		
Name	Title		
Development Support Group	jwdsg@comcast.net		
Company Name	E-Mail Address		
4219 Hillsboro Road, Suite 210	Nashville	TN	37215
Street or Route	City State Zip Code		
CON Consultant	615-665-2022		615-665-2042
Association With Owner	Phone Number		Fax Number

#### 3. Owner of the Facility, Agency, or Institution

The Endoscopy Center of Knoxville, L.P.		615-240-3702
Name		Phone Number
c/o Amsurg Corp, 1A Burton Hills Boulevard		Davidson
Street or Route		County
Nashville	TN	XXXXX
City	State	Zip Code

#### 4. Type of Ownership or Control (Check One)

		F. Government (State of TN or
A. Sole Proprietorship		Political Subdivision)
B. Partnership		G. Joint Venture
C. Limited Partnership	х	H. Limited Liability Company
D. Corporation (For-Profit)		I. Other (Specify):
E. Corporation (Not-for-Profit)		

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS

### 5. Name of Management/Operating Entity (If Applicable)

AmSurg Corp		
Name		D 11
1 Burton Hills Boulevard		Davidson
Street or Route		County
Nashville Nashville	TN	37215
City	State	Zip Code
Cuv		-

## 6. Legal Interest in the Site of the Institution (Check One)

A. Ownership		D. Option to Lease	
B. Option to Purchase		E. Other (Specify):	
C. Lease of 15 Years	X		

## 7. Type of Institution (Check as appropriate—more than one may apply)

A. Hospital (Specify): General		I. Nursing Home	
B. Ambulatory Surgical Treatment Center (ASTC) Multi-Specialty		J. Outpatient Diagnostic Center	
C. ASTC, Single Specialty	X	K. Recuperation Center	
D. Home Health Agency		L. Rehabilitation Center	
E. Hospice		M. Residential Hospice	
F. Mental Health Hospital		N. Non-Residential Methadone	
G. Mental Health Residential Faclity		O. Birthing Center	
H. Mental Retardation Institutional Habilitation Facility (ICF/MR)		P. Other Outpatient Facility (Specify):	
THOMAS A WILLIAM		Q. Other (Specify):	

## 8. Purpose of Review (Check as appropriate—more than one may apply

	G. Change in Bed Complement Please underline the type of Change: Increase, Decrease, Designation,	
A. New Institution	Distribution, Conversion, Relocation	
B. Replacement/Existing Facility	H. Change of Location	X
C. Modification/Existing Facility	I. Other (Specify):	
D. Initiation of Health Care Service as defined in TCA Sec 68-11-1607(4) (Specify)	Reduction of Procedure Rooms	x
E. Discontinuance of OB Service		-
F. Acquisition of Equipment		

9. Bed Complement Data

NA

(Please indicate current and proposed distribution and certification of facility beds.)

		CON			
	Current	approved beds		Beds	TOTAL
	Licensed	(not in	Staffed	Proposed	Beds at
	Beds	service)	Beds	(Change)	Completion
A. Medical					
B. Surgical					
C. Long Term Care Hosp.					
D. Obstetrical					
E. ICU/CCU					
F. Neonatal					
G. Pediatric					
H. Adult Psychiatric					
I. Geriatric Psychiatric					
J. Child/Adolesc. Psych.					
K. Rehabilitation					
L. Nursing Facility					
(non-Medicaid certified)					
M. Nursing Facility Lev. 1					
(Medicaid only)					
N. Nursing Facility Lev. 2					
(Medicare only)					
O Nursing Facility Lev. 2					
(dually certified for		1			
Medicare & Medicaid)					
P. ICF/MR					
Q. Adult Chemical					
Dependency					
R. Child/Adolescent					
Chemical Dependency					
S. Swing Beds					
T. Mental Health					
Residential Treatment					
U. Residential Hospice					
TOTAL					

10. Medicare Provider Number:	3287442	
Certification Type:	Ambulatory Surgical Treatment Center	
11. Medicaid Provider Number:	3287442	
Certification Type:	Ambulatory Surgical Treatment Center	

#### 12. & 13. See page 4

# A.12. IF THIS IS A NEW FACILITY, WILL CERTIFICATION BE SOUGHT FOR MEDICARE AND/OR MEDICAID?

The applicant is an existing facility that already participates in both Medicare and TennCare/Medicaid. A change of site will not affect those certifications because the licensee will remain unchanged.

A.13. IDENTIFY ALL TENNCARE MANAGED CARE ORGANIZATIONS / BEHAVIORAL HEALTH ORGANIZATIONS (MCO'S/BHO'S) OPERATING IN THE PROPOSED SERVICE AREA. WILL THIS PROJECT INVOLVE THE TREATMENT OF TENNCARE PARTICIPANTS? Yes IF THE RESPONSE TO THIS ITEM IS YES, PLEASE IDENTIFY ALL MCO'S WITH WHICH THE APPLICANT HAS CONTRACTED OR PLANS TO CONTRACT.

# DISCUSS ANY OUT-OF-NETWORK RELATIONSHIPS IN PLACE WITH MCO'S/BHO'S IN THE AREA.

The Endoscopy Center of Knoxville is contracted with three of Tennessee's four MCO's. At the time of filing this application, it has submitted its credentialing application to Amerigroup and is awaiting an agreement.

Available TennCare MCO's	Applicant's Relationship
AmeriGroup	contract requested and pending
United Healthcare Community Plan	contracted
BlueCare	contracted
TennCare Select	contracted

SECTION B: PROJECT DESCRIPTION

B.I. PROVIDE A BRIEF EXECUTIVE SUMMARY OF THE PROJECT NOT TO EXCEED TWO PAGES. TOPICS TO BE INCLUDED IN THE EXECUTIVE SUMMARY ARE A BRIEF DESCRIPTION OF PROPOSED SERVICES AND EQUIPMENT, OWNERSHIP STRUCTURE, SERVICE AREA, NEED, EXISTING RESOURCES, PROJECT COST, FUNDING, FINANCIAL FEASIBILITY AND STAFFING.

#### Proposed Services and Equipment

- The Endoscopy Center in Knoxville is an ambulatory surgical treatment center (ASTC) limited to endoscopy. It has operated for almost 29 years at its current location in Knox County. It has eight procedure rooms.
- This application is to relocate the facility 1.4 miles within Knox County, to larger leased space in a building to be constructed in the Dowell Springs development north of I-40. The project site is across Middlebrook Pike from the future site of the Tennova Physicians Regional Medical Center (an unrelated facility). In the move, The Endoscopy Center will reduce its capacity from eight (8) to six (6) procedure rooms. The Center will lease one floor of the new building. Gastroenterology Associates (GIA), a physician group practice who are the medical staff of the Center, will also lease a floor there.

#### Ownership Structure

- The facility is owned by The Endoscopy Center of Knoxville, L.P. This limited partnership's general partner is AmSurg KEC, Inc., a wholly owned subsidiary of AmSurg Corp. The L.P.'s limited partner is "The Endoscopy Center" (a Tennessee general partnership composed of nine gastroenterologists in the medical practice named Gastrointestinal Associates). AmSurg Corp has a management contract with the ASTC.
- Attachment A.4 contains more details, an organization chart, and information on the Tennessee facilities owned by AmSurg.

#### Service Area

• The ASTC's primary service area, from which 82% of its cases come, consists of Knox, Sevier, Jefferson, Blount, Anderson, and Hamblen Counties in East Tennessee.

#### Need

• When this facility opened in 1986, it shared some support spaces with Gastrointestinal Associates ("GIA"), its medical staff's private group practice office. Several years ago, Medicare compelled surgery centers nationwide to stop sharing space with adjoining medical practices, including even shared waiting areas. The ASTC had no adjoining space into which it could expand to create such a separation. So the ASTC and the medical practice obtained Medicare and State licensing approval for the ASTC to use the space exclusively, from 7 AM to 12 noon, while the practice would use the space from 12 noon to 5 PM. This reduced the ASTC's surgical schedule (formerly 7 AM-5PM) by 50% in mid-2013.

- That limitation to half-time operation, the subsequent death of the Endoscopy Center's busiest surgeon, and the obsolete design of the small, almost 29-year-old facility all combined to decrease annual utilization after June of 2013: from 11,251 cases in CY 2013 to a projected 9,560 cases in CY2015, the current year.
- This project will address those limitations by providing a 7 AM to 4 PM five-day-a-week, efficient workspace in a new building with excellent patient access, not far from the ASTC's current location. The Endoscopy Center has commitments from two physicians who will add 3,100 cases at the new location in CY2017. In its second year of operation at the new site, the Center will perform 12,981 total cases. The State health Plan optimal standard (70% occupancy) of 1,867 cases per room indicates a need for 7.0 procedure rooms. AmSurg's own internal standard indicates a need for 6 rooms. This application is proposing 6 procedure rooms, which will reduce service area capacity by 2 procedure rooms.
- Apart from the need to escape capacity limitations of a half-day surgical schedule, The Endoscopy Center's almost 29-year old, tiny 3,686-SF floor plan no longer meets current endoscopy center design standards. Much larger, more efficient, and more comfortable spaces are essential to provide an optimal care experience for these patients.

#### Existing Resources

• In the primary service area, seven surgery centers reported performing endoscopies in one or more years from FYE 2012 to FYE 2014. Their utilization of their procedure rooms was last reported at 1,667 cases per room in FYE 2014--89% of the State Health Plan's optimal standard for procedure room utilization.

#### Project Cost, Funding, Financial Feasibility

• The cost for CON purposes is estimated at \$13,791,719. However, that includes the new location's lease payments for fifteen years. Excluding that, the applicant's actual capital expenditure required for the project is estimated at \$6,880,919. That will be the applicant's cost for obtaining the CON and for building out and equipping the floor space it will lease for the project. The applicant's costs will be funded by a loan from AmSurg Corp., the general partner and manager of this facility. (AmSurg is not funding the developer's cost of providing the shelled floor). The facility reported a positive operating margin in 2014. Continued positive operating margins are anticipated at the new location, with increased utilization.

#### Staffing

• The Endoscopy Center (Knoxville) today has 42.2 FTE's. In Year Two at the new location, the facility projects having 50.7 FTE's on staff.

B.II. PROVIDE A DETAILED NARRATIVE OF THE PROJECT BY ADDRESSING THE FOLLOWING ITEMS AS THEY RELATE TO THE PROPOSAL.

B.II.A. DESCRIBE THE CONSTRUCTION, MODIFICATION AND/OR RENOVATION OF THE FACILITY (EXCLUSIVE OF MAJOR MEDICAL EQUIPMENT COVERED BY T.C.A. 68-11-1601 et seq.) INCLUDING SQUARE FOOTAGE, MAJOR OPERATIONAL AREAS, ROOM CONFIGURATION, ETC.

#### Physical Description of the Project

The applicant facility, The Endoscopy Center ("TEC") is a single-specialty ambulatory surgical treatment center limited to endoscopy. It has been located at 801 Weisgarber Road in Knoxville for almost 29 years. It has 8 procedure rooms.

In this application, The Endoscopy Center proposes to move in late 2016 to leased second-floor space in a new building that will be constructed in the Dowell Springs area of central Knox County, close to I-40. The 4.53-acre site is 1.4 miles from TEC's present location. The site is in the northwest quadrant of the intersection of Dowell Springs Boulevard and Middlebrook Pike (TN Highway 169)--directly across Middlebrook Pike from the future site of the Physicians Regional Medical Center.

At the new location, TEC will utilize 16,732 usable SF of space, containing 6 endoscopy procedure rooms--2 fewer rooms than at present. It will expand its preparation and recovery areas from its current 7 pre-op and post-op recovery stations, to 18 pre-op and post-op recovery stations. The design includes two large waiting rooms-one for patients and another for waiting families. The plan also provides all required support areas, such as staff lockers, showers, and break room; a biohazard room, and supply storage.

A floor plan of the proposed new space is attached following this page. Additional plans are in the Attachments.

	<b>KEFERENCE</b> :
СОИ	SHEET#:
06/22/2015	:3TAQ
9704r	PROJECT#:

# DOMET SPRINGS THE ENDOSCOPY CENTER THE ENDOSCOPY CENTER



402 S. (3ay Street, Suite 201, Knoxville, TN 37902 ph 865,637,8540 or 865,291,2221 fx 865,544,3840 www.die-arch.com

ROOM LISTING ROOM NO. NAME 280 PATIENT ADV. 284 PATIENT ADV. 285 PATIENT ADV. 286 CRASH 286 CRASH 286 CRASH 286 CLINEN WHEEL CHAIR 286 SUPPLY 280 LINEN WHEEL CHAIR 280 LINEN WH
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ROOM LISTING  ROOM NO. ROOM  NO. NAME  233 PATIENT TOILET  234 JANTOR  235 AIR LOCK  236 GURNEY  237 BIO HAZARD  240 COKER  241 SHOWER  244 SHOWER  245 LOCKER  245 LOCKER  246 CORRIDOR  246 CORRIDOR  247 BREAK ROOM  280  280  281  282  282  284  285  285  285  286  286  286  287  288  288  288  289  280  280  280  280
ROOM LISTING  ROOM  NO. NAME  216 PRE-OP  217 PATIENT TOILET  218 PRE-OP  220 PROCEDURE  221 PROCEDURE  222 PROCEDURE  223 PROCEDURE  224 CORRIDOR  226 SOOPES STORAGE  227 SCOPES STORAGE  228 WASH  230 PRE-WASH  231 LINEN  231 LINEN  232 PROCEDURE  233 PROCEDURE  234 PROCEDURE  235 PROCEDURE  236 PROCEDURE  237 PROCEDURE  238 PROCEDURE  238 PROCEDURE  239 PROCEDURE  230 PRE-WASH  231 PROCEDURE  230 PRE-WASH  231 PROCEDURE  232 PROCEDURE  233 PROCEDURE  234 PROCEDURE  235 PROCEDURE  236 PROCEDURE  237 PROCEDURE  238 PROCEDURE  238 PROCEDURE  239 PROCEDURE  230 PRE-WASH  230 PRE-WASH  230 PRE-WASH  230 PRE-WASH  231 PROCEDURE  230 PRE-WASH  231 PROCEDURE  231 PROCEDURE  232 PROCEDURE  233 PROCEDURE  234 PROCEDURE  235 PROCEDURE  236 PROCEDURE  237 PROCEDURE  238 PROCEDURE  238 PROCEDURE  239 PROCEDURE  230 PRE-WASH  230 PROCEDURE  230 PRE-WASH  230 PROCEDURE  230 PR
ROOM LISTING  ROOM  NO. NATING 33 SEATS  201 CORRIDOR  202 CORRIDOR  203 PATIENT TOILET  204 SELF CHECK-IN  205 GREETER  206 BATIENT TOILET  207 CORRIDOR  208 DATIENT TOILET  209 PATIENT TOILET  208 DATIENT

#### Construction Scope and Cost

Tables Two-A and -B below summarize the scope of proposed changes in size and the applicant's build-out/renovation costs at the proposed Dowell Springs location.

Table Two-A: Summary of Construction and Changes in Size			
Space At Current Site	3,686 SF		
Space At Proposed Location	16,732 SF		
Area of New Construction By Lessee	0 SF		
Area of Build-out or Renovation by Lessee	16,732 SF		
Total Construction Project	16,732 SF		

Table Two-B: Construction Costs of This Project					
Applicant's Applicant's Applicant's Renovation New Construction Total Construc					
Square Feet	16,732 SF	0	16,732 SF		
Construction Cost	\$4,300,124	0	\$4,300,124		
Constr. Cost PSF	\$257 PSF	0	\$257 PSF		

#### Operational Schedule and Open Medical Staff

The Endoscopy Center will expand its operating hours of 7 am to 12 noon, to 7 am to 4 pm, five days per week, Monday through Friday, throughout the year. Calendar year 2017 is projected to be the first full year of operation at the new location. The facility has, and will continue to have, an open medical staff, for appropriately accredited gastroenterologists.

#### Cost and Funding

The cost for CON purposes is estimated at \$13,791,719. However, that includes the new location's lease expense over fifteen years. Excluding that operational cost, the applicant's real capital cost for completing and occupying its floor at the new location is estimated at \$6,408,504. All of that will be provided in the form of a loan from AmSurg Corp, the general partner of the applicant.

#### Ownership of the Applicant

The Endoscopy Center is, and will continue to be, owned by The Endoscopy Center of Knoxville, L.P. (the CON applicant). That L.P.'s 51% general partner is AmSurg KEC, Inc., a subsidiary of AmSurg Corp, a publicly traded company. The L.P.'s 49% <u>limited partner</u> is "The Endoscopy Center", which is a Tennessee general partnership composed of nine gastroenterologists in the medical practice named Gastroenterology Associates, or "GIA". Physician owners of the limited partner are:

Table Two-C: The Endoscopy Center of Knoxville, L.P.				
		Limited Partner (49%)		
General Partner (51%)		The Endoscopy Center		
AmSurg KEC, Inc.		(A Tennessee General Partn	ership)	
	Percent	1		
	of		Percent	
	General		of Ltd	
Owner	Partner	Owners (All M.D.'s in GIA)	Partner	
		1. Barry V. Mayes	11.111%	
AmSurg Corp	100%	2. Sarkis J. Chobanian	11.111%	
<b>U</b> 1		3. Charles M. O'Connor	11.111%	
		4. Meade C. Edmunds	11.111%	
		5. John M. Haydek	11.111%	
		6. Maria B. Newman	11.111%	
		7. Raj I. Narayani	11.111%	
		8. Steven J. Bindrim	11.111%	
		9. Scott L. Wilhoite	11.111%	

Ownership interests in the applicant, and in the entities owning the applicant, will not change in this project. The ASTC's surgical staff now consists of the 9 GIA gastroenterologists listed above, and 3 other GIA gastroenterologists (Drs. Matthew Moore, Johnny Altavil, and Bergein Overholt) who are not limited partners. Dr. Jeff Gilbert will join GIA in September 2015; he will have privileges at the ASTC, but will not be a limited partner.

APPLICANTS WITH HOSPITAL PROJECTS (CONSTRUCTION COST IN EXCESS OF \$5 MILLION) AND OTHER FACILITY PROJECTS (CONSTRUCTION COST IN EXCESS OF \$2 MILLION) SHOULD COMPLETE THE SQUARE FOOTAGE AND COSTS PER SQUARE FOOTAGE CHART....

See Attachment B.II.A.

## PLEASE ALSO DISCUSS AND JUSTIFY THE COST PER SQUARE FOOT FOR THIS PROJECT.

The HSDA has calculated 2012-2014 ASTC construction cost averages for approved projects. However, there were too few samples to calculate renovation or new construction costs separately.

Ambulatory Surgery Center Construction Cost PSF Years: 2012-2014					
Renovated New Total Construction Construction					
1 <sup>st</sup> Quartile	\$0/sq ft	\$0/sq ft	\$113.55/sq ft		
Median	\$0/sq ft	\$0/sq ft	\$150.00/sq ft		
3 <sup>rd</sup> Quartile	\$0/sq ft	\$0/sq ft	\$174.88/sq ft		

Source: HSDA Registry; CON approved applications for years 2012 through 2014

However, surgery center construction projects approved by the HSDA in 2011-2013 had the following construction costs per SF:

Ambulatory Surgery Center Construction Cost PSF Years: 2011-2013							
	Renovated New Total						
	Construction Construction Construction						
1 <sup>st</sup> Quartile \$95.04/sq ft \$174.88/sq ft \$113.55/s							
Median \$113.55/sq ft \$223.62/sq ft \$162.00/sq ft							
3 <sup>rd</sup> Quartile	\$150.00/sq ft	\$269.76/sq ft	\$223.62/sq ft				

Source: HSDA Registry; CON approved applications for years 2011 through 2013

The applicant's build-out (renovation) cost of \$257 PSF is above the HSDA's last calculated average third quartile cost for ASTC's. But this is reasonable due to the steady annual increase in construction costs since 2011, and the costs in the Knoxville market for such projects. The construction will be paid for in 2016, which is four years beyond the midpoint of the HSDA 2011-13 range.

Table Two-B (Repeated): Construction Costs of This Project					
	Applicant's Total Construction				
	Renovation	New Construction			
Square Feet	16,732 SF	0	16,732 SF		
Construction Cost	\$4,300,124	0	\$4,300,124		
Constr. Cost PSF	\$257 PSF	0	\$257 PSF		

IF THE PROJECT INVOLVES NONE OF THE ABOVE, DESCRIBE THE DEVELOPMENT OF THE PROPOSAL.

Not applicable.

B.II.B. IDENTIFY THE NUMBER AND TYPE OF BEDS INCREASED, DECREASED, CONVERTED, RELOCATED, DESIGNATED, AND/OR REDISTRIBUTED BY THIS APPLICATION. DESCRIBE THE REASONS FOR CHANGE IN BED ALLOCATIONS AND DESCRIBE THE IMPACT THE BED CHANGE WILL HAVE ON EXISTING SERVICES.

Not applicable to an ambulatory surgical treatment facility.

B.II.C. AS THE APPLICANT, DESCRIBE YOUR NEED TO PROVIDE THE FOLLOWING HEALTH CARE SERVICES (IF APPLICABLE TO THIS APPLICATION): (NEW SERVICE LIST OMITTED)....

Not applicable. No services are being added to this facility. This is a relocation of an existing facility with no change in its scope of services.

# B.II.D. DESCRIBE THE NEED TO CHANGE LOCATION OR REPLACE AN EXISTING FACILITY.

#### The Need to Relocate to Another Building

Historically, The Endoscopy Center on Weisgbarber Road in Knoxville was one of the earliest endoscopic ambulatory surgery centers developed in Tennessee. It opened in 1986, almost three decades ago. It was also the Knoxville region's largest ASTC provider of outpatient endoscopic cases until July of 2013. In the fiscal year ending June 2013, of the seven area ASTC's who performed endoscopic cases, The Endoscopy Center performed almost 30% of all those cases and performed 64% more cases than the next-highest provider.

Between 2010 and 2013, Medicare directed surgery centers nationwide to cease all space-sharing arrangements with adjoining physician practice offices. Up to that time, it was commonplace--and very economical--for surgery centers to share areas such as reception, waiting, and business with the physician group practices that constituted their medical staffs. The Endoscopy Center shared some spaces with its associated medical practice, Gastrointestinal Associates ("GIA").

Threatened with loss of Medicare reimbursement, but with no expansion room available in its Weisgarber Road building, and with lease commitments, The Endoscopy Center's only way to comply with Medicare's new space-sharing prohibition was to negotiate a temporary time-sharing agreement with the medical practice (GIA), that was acceptable to Medicare and to State Licensure. The agreement gave the Center exclusive use of the entire premises from 7 AM to noon daily, with GIA using the entire premises exclusively as a gastroenterology group practice office during the afternoons. This operational arrangement is still in effect.

The sudden reduction of *effective* surgical capacity by a required closure at noon, and the death of the center's busiest surgeon (who performed approximately 1,500 cases per year), caused the center's utilization to decline the following year by 15%--from 11,251 cases in CY2013 to a projected 9,560 cases in CY2015. With additional

physician recruitment since 2013, utilization is slowly increasing, but the limitation to half-day operation is a severe restraint on case referrals to this practice and to its ASTC. It is not sustainable to continue this truncated operating schedule indefinitely. Relocation to another site with complete separation of the endoscopy center from the GIA practice office is essential to restore normal utilization of this facility. GIA also needs to restore a normal workday for its group practice office, as its staff increases with new recruitment and as an aging population requires ever more endoscopic care.

It is also time to modernize The Endoscopy Center's physical space. Designed three decades ago, the current space has many limitations other than its mornings-only surgical schedule. AIA and State requirements have changed significantly in three decades.

More pre-op and recovery stations will be needed to accommodate increasing demand for services over the next several years. Their positioning for line-of-sight supervision needs to be improved. They need more hard-walled stations to provide patients with more privacy and quiet than is now possible with only curtained gurney bays. The Center needs more Pre-op stations to ensure efficient throughput of cases during busy periods. It needs more Recovery stations to avoid bottlenecks that tie up procedure rooms, i.e., when recovery stations are full and patients who have completed surgery have to recover in the procedure room itself, delaying that room's use for the next scheduled patient. One larger procedure room needs to be provided for specialized equipment to be used in certain cases.

Within the procedure rooms, electrical equipment needs to connect with power sources descending from the ceiling, rather than having wires trailing underfoot across procedure room floors. For optimal infection control, automatic doors are needed to replace hand-operated doors in some areas, so that (a) nurses transporting non-sterile scopes do not have to touch door handles, risking contamination of the handles, and (b) nurses transporting sterile scopes do not have to touch door handles, risking contamination of the scopes they carry.

Ambulance and non-ambulance patient access needs to be improved. Currently all patients come in the front door through the waiting room; and they leave the same

way. In the new location, a separate ambulance entry is provided, giving patients more privacy. And in the new design, families whose patients have been taken to surgery will wait for them in a second waiting area that is separate from the one for arriving patients and families. Discharge after recovery will be more private, with patient exits separated from the view of the waiting rooms. Airlocks will be provided for all-weather comfort and privacy in exiting the building, and for arriving ambulance patients.

#### Need For Six Procedure Rooms (Decrease of Two Rooms)

The facility's annualized CY2015 utilization based on January-June is 9,560 cases. In CY2016, at the current location, facility management projects that normal growth in physician referrals will increase utilization by at least 1%, to 9,656 cases. In CY2017, even at the current location, normal growth brought by existing medical staff will again increase utilization by 1%, to 9,752 cases.

But if the proposed relocation is approved, allowing normal full-day operation, an *additional* 3,100 new cases will be brought to the new location in CY2017 by two physicians who currently do not have room to perform their cases at this facility. Dr. Jeff Gilbert, an established Anderson County gastroenterologist, is joining the Center in late 2015. He projects bringing 2,200 of his current cases to the new location in CY2017-600 cases currently being performed at two Knox County endoscopy centers owned by this same applicant, plus 300 new cases from normal practice growth between 2015 and 2017. Dr. Gilbert's and Dr. Moore's letter attesting to these new cases are provided in the Attachments.

In CY2017, with a normal full-day surgical schedule resumed at the new location, and with Dr. Gilbert and Dr. Moore's transferred cases, The Endoscopy Center projects a first-year caseload of 12,852 cases. The following year the Center projects a continuing 1% increase in utilization, to 12,981 cases.

Table Three-A below shows that the projected occupancy on the proposed facility is consistent with the Guidelines of the State Health Plan. The Table shows surgical room utilization as a percent of three standards: (a) Amsurg's broad general goal

of performing 2,500 cases per room; (b) the State Health Plan's "optimal" goal of 1,867 cases per room (70% occupancy); and (c) the State Health Plan's definition of 100% occupancy for a procedure room.

The project will operate in Year Two (2018) at approximately 116% of the State Health Plan's optimal efficiency standard. It will operate at 86.6% of AmSurg's own higher expectation for this type of facility.

	Table Three-A: The Endoscopy Center (Knoxville) Historical and Projected Utilization 2012-2018 (Year Two) Patients/Cases						
Percent of State Health P AmSurg Health Plan Full Cases Optimal Cases of Ca							
Year (Historical)	Rooms	Cases	Room	2,500 / Rm	1,007 / 1411	2,667 / Rm	
CY 2012	8	11,462	1,433	57.3%	76.8%	53.7%	
CY 2013	8	11,251	1,406	56.2%	75.3%	52.7%	
CY 2014	8	9,652	1,207	48.3%	64.6%	45.3%	
(Projected)							
CY 2015	8	9,560	1,195	47.8%	64.0%	44.8%	
CY 2016	8	9,656	1,207	48.3%	64.7%	45.3%	
CY 2017-Yr 1	6	12,852	2,142	85.7%	114.7%	80.3%	
CY 2018-Yr 2	6	12,981	2,164	86.6%	115.9%	81.1%	

Sources: FY2012-15 historical cases from AmSurg management and facility records; 2015 annualized on Jan-June. CY2016-18 projected cases from AmSurg management.

Converting this utilization into room need, Table Three-B on the following page shows the procedure rooms that the projected utilization needs under AmSurg's and the State Health Plan's standards. Under the State Health Plan's optimal occupancy standard, seven procedure rooms will be needed in CY2018, Year Two. AmSurg's standard indicates that with a need for 5.2 procedure rooms, 6 rooms will be appropriate and will provide room for future growth. Consistent with that, 6 rooms are being proposed in this application. That will be a decrease of 2 rooms from the current 8-room license.

#### Table Three-B: The Endoscopy Center (Knoxville) Procedure Room Need Based on AmSurg and State Health Plan **Utilization Standards** Room Need At **Room Need State Health** At AmSurg Plan Optimal Cases Goal of 2500 Standard of Procedure Per 1,867 Cases **Cases Per** Year Rooms Cases Room Room Per Room (Historical) CY 2012 8 11,462 1,433 4.6 6.1 CY 2013 11,251 1,406 6.0 8 4.5 CY2014 3.9 5.2 8 9,652 1,207 (Projected) 1,195 CY 2015 Ann'd 8 9,560 3.8 5.1 CY 2016 1,207 3.9 5.2 8 9,656 CY 2017-Yr 1 6 12,852 2,142 5.1 6.9 7.0 CY 2018-Yr 2 12,981 2,164 5.2 6

Sources: Table Three-A.

#### Service Area Need for Services

The Center of Disease Controls website shows that colorectal cancer incidence in Tennessee is 40.1 to 42.6 persons per 100,000 population, in the third highest national quartile. However, Tennessee is one of twelve States in the highest quartile for deaths from that disease, at 16.5 to 19.9 persons per 100,000 population. This is linked to the fact that only 59.3% to 63.5% of Tennessee adults age 50-75 years are "up to date", i.e., compliant with, recommended periodic colon cancer screening guidelines. Screening endoscopies are essential to identify and surgically remove pre-cancerous polyps and early-stage colon cancers. Screening guidelines call for this procedure to be performed on all persons 50 years of age or older, every ten years--or every five years if high-risk. Table Three-C below shows potential cases of colon cancer in this project's service area.

Table Three-	Table Three-C: Potential Colon Cancer Patients, Primary Service Area					
			Predicted 2015			
PSA County	Rate / 100,000	2015 Population	Cases			
Anderson	40.1 to 42.6	76,949	31 - 33			
Blount	40.1 to 42.6	129,973	52 - 55			
Hamblen	40.1 to 42.6	64,438	26 - 27			
Jefferson	40.1 to 42.6	54,482	22 - 23			
Knox	40.1 to 42.6	459,124	184 - 196			
Sevier	40.1 to 42.6	96,116	39 - 41			
PSA Total		881,082	353 - 375			

Source: CDC; TDH

B.II.E. DESCRIBE THE ACQUISITION OF ANY ITEM OF MAJOR MEDICAL EQUIPMENT (AS DEFINED BY THE AGENCY RULES AND THE STATUTE) WHICH EXCEEDS A COST OF \$1.5 MILLION; AND/OR IS A MAGNETIC RESONANCE IMAGING SCANNER (MRI), POSITRON EMISSION TOMOGRAPHY (PET) SCANNER, EXTRACORPOREAL LITHOTRIPTER AND/OR LINEAR ACCELERATOR BY RESPONDING TO THE FOLLOWING:

- 1. For fixed site major medical equipment (not replacing existing equipment):
  - a. Describe the new equipment, including:
    - 1. Total Cost (As defined by Agency Rule);
    - 2. Expected Useful Life;
    - 3. List of clinical applications to be provided; and
    - 4. Documentation of FDA approval.
  - b. Provide current and proposed schedule of operations.
- 2. For mobile major medical equipment:
  - a. List all sites that will be served;
  - b. Provide current and/or proposed schedule of operations;
  - c. Provide the lease or contract cost;
  - d. Provide the fair market value of the equipment; and
  - e. List the owner for the equipment.
- 3. Indicate applicant's legal interest in equipment (e.g., purchase, lease, etc.) In the case of equipment purchase, include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

Not applicable. No major medical equipment is proposed in this project.

B.III.A. ATTACH A COPY OF THE PLOT PLAN OF THE SITE ON AN 8-1/2" X 11" SHEET OF WHITE PAPER WHICH MUST INCLUDE:

- 1. SIZE OF SITE (IN ACRES);
- 2. LOCATION OF STRUCTURE ON THE SITE;
- 3. LOCATION OF THE PROPOSED CONSTRUCTION; AND
- 4. NAMES OF STREETS, ROADS OR HIGHWAYS THAT CROSS OR BORDER THE SITE.

PLEASE NOTE THAT THE DRAWINGS DO NOT NEED TO BE DRAWN TO SCALE. PLOT PLANS ARE REQUIRED FOR ALL PROJECTS.

See Attachment B.III.A.

B.III.B.1. DESCRIBE THE RELATIONSHIP OF THE SITE TO PUBLIC TRANSPORTATION ROUTES, IF ANY, AND TO ANY HIGHWAY OR MAJOR ROAD DEVELOPMENTS IN THE AREA. DESCRIBE THE ACCESSIBILITY OF THE PROPOSED SITE TO PATIENTS/CLIENTS.

The site is within five minutes' drive of Exit 388 (Papermill/Weisgarber Road) on I-40 in Knoxville, central to that city, and central to the region the project will serve. Interstates and good Federal and State highways connect Knoxville to all parts of the service area, whose residents look to Knoxville for tertiary, specialized care when that is not available in their home communities. City and regional location maps are provided in Attachment C, Need—3.

KAT (Knoxville Area Transit) operates bus service along Middlebrook Pike and up Dowell Springs Boulevard, already providing bus service directly by` the project site at the intersection of those two streets. Please see the KAT bus route map in Attachment C,Need--3, Service Area Maps.

The drive time Tables Four-A and -B on the following page provide driving distance and times between both the current and proposed sites, and major communities in the service area, and from the proposed site to other area ASTC's that currently perform endoscopic surgery.

The relocation will improve physical accessibility for the applicant's patients, because of its higher visibility in a stand-alone building, at a major intersection in the developing area of Dowell Springs, directly across the street from the future Physicians Regional Medical Center campus.

Table Four-A: Mileage and Drive Times From the Applicant's Current and Proposed Sites to Major Communities in the Project's Primary Service Area						
		To Prop	osed Site	To Cur	rent Site	
County	City	Miles	Minutes	Miles	Minutes	
Knox	Farragut	11.6	18 min.	12.3	17 min.	
	Powell	9.0	19 min.	12.5	16 min.	
	Halls Crossroads	14.3	20 min.	14.4	18 min.	
	Seymour	19.1	33 min.	17.7	27 min.	
Sevier	Sevierville	32.3	49 min.	30.9	44 min.	
Jefferson	Jefferson City	34.7	43 min.	33.3	39 min.	
Blount	Maryville	21.2	30 min.	19.9	27 min.	
Anderson	Clinton	17.4	29 min.	20.7	29 min.	
	Oak Ridge	19.4	27 min.	20.1	26 min.	
Hamblen	Morristown	53.9	56 min.	52.6	53 min.	
Aver	age Drive Time		32.4 min.		29.6 min.	

Average Drive Time
Source: Google Maps, June, 2015.

Table Four-B: Mileage and Drive Times Between the Project and Other ASTC's Performing Endoscopies in the Project's Tennessee Primary Service Area						
Facility and Address	County and State	Distance in Miles	Drive Time in Minutes			
Children's West Surgery Center 1020 Children's Way, Knoxville 37922	Knox TN	11.7	17 min.			
Fort Sanders West OP Surgery Center 210 Ft. Sanders W. Boulevard, Knoxville 37909	Knox TN	9.4	16 min.			
Parkwest Surgery Center 9430 Parkwest Boulevard, Knoxville 37923	Knox TN	6.7	12 min.			
The Endoscopy Center North 629 Delozier Way, Powell 37849	Knox TN	11.3	18 min.			
The Endoscopy Center West 11440 Parkside Drive, Knoxville 37934	Knox TN	12.3	19 min.			
Tennessee Endoscopy Center 1706 E. Lamar Alexander Pkwy, Maryville 37804	Blount TN	22.1	31 min.			

Source: Google Maps, July 2015.

B.IV. ATTACH A FLOOR PLAN DRAWING FOR THE FACILITY WHICH INCLUDES PATIENT CARE ROOMS (NOTING PRIVATE OR SEMI-PRIVATE), ANCILLARY AREAS, EQUIPMENT AREAS, ETC.

See attachment B.IV.

#### IV. FOR A HOME CARE ORGANIZATION, IDENTIFY

- 1. EXISTING SERVICE AREA (BY COUNTY);
- 2. PROPOSED SERVICE AREA (BY COUNTY);
- 3. A PARENT OR PRIMARY SERVICE PROVIDER;
- 4. EXISTING BRANCHES AND/OR SUB-UNITS; AND
- 5. PROPOSED BRANCHES AND/OR SUBUNITS.

Not applicable. The application is not for a home care organization.

#### C(I) NEED

- C(I).1. DESCRIBE THE RELATIONSHIP OF THIS PROPOSAL TO THE IMPLEMENTATION OF THE STATE HEALTH PLAN AND TENNESSEE'S HEALTH: GUIDELINES FOR GROWTH.
- A. PLEASE PROVIDE A RESPONSE TO EACH CRITERION AND STANDARD IN CON CATEGORIES THAT ARE APPLICABLE TO THE PROPOSED PROJECT. DO NOT PROVIDE RESPONSES TO GENERAL CRITERIA AND STANDARDS (PAGES 6-9) HERE.
- B. APPLICATIONS THAT INCLUDE A CHANGE OF SITE FOR A HEALTH CARE INSTITUTION, PROVIDE A RESPONSE TO GENERAL CRITERION AND STANDARDS (4)(a-c).

Project-Specific Review Criteria: Ambulatory Surgical Treatment Centers (2012 State Health Plan)

#### Assumptions in Determination of Need

The need for an ambulatory surgical treatment center shall be based upon the following assumptions:

#### 1. Operating Rooms

- a. An operating room is available 250 days per year, 8 hours per day.
- b. The estimated average time per Case in an Operating Room is 65 minutes.
- c. The average time for clean up and preparation between Operating Room Cases is 30 minutes.
- d. The optimum utilization of a dedicated, outpatient, general-purpose Operating Room is 70% of full capacity. 70% x 250 days/year x 8 hours/day divided by 95 minutes = 884 Cases per year.

Criteria 1a-1d above are not applicable. The facility will not have any Operating Rooms; it will have only Procedure Rooms.

#### 2. Procedure Rooms

a. A procedure room is available 250 days per year, 8 hours per day.

Complies. The Endoscopy Center will be operated from 7 am to 4 pm Monday through Friday, 50 weeks per year.

b. The estimated average time per outpatient Case in a procedure room is 30 minutes.

Complies. The average time per case (excluding room turnaround) is projected to be 25 minutes.

c. The average time for clean up and preparation between Procedure Room Cases is 15 minutes.

Complies. The average time allowed for room turnaround between endoscopy cases is projected to be 10 minutes.

d. The optimum utilization of a dedicated, outpatient, general-purpose outpatient Procedure Room is 70% of full capacity. 70% x 250 days/year x 8 hours/day divided by 45 minutes = 1867 Cases per year.

Complies. In Year Two (CY 2018), the facility's projected utilization of 12,981 cases demonstrates a need for 7 procedure rooms at the optimal standard (12,981 / 1,867 = 7.0 rooms). Only 6 rooms are proposed in the project.

#### **Determination of Need**

1. Need. The minimum numbers of 884 Cases per Operating Room and 1867 Cases per Procedure Room are to be considered as baseline numbers for purposes of determining Need. An applicant should demonstrate the ability to perform a minimum of 884 Cases per Operating Room and/or 1867 Cases per Procedure Room per year, except that an applicant may provide information on its projected case types and its assumptions of estimated average time and clean up and preparation time per Case if this information differs significantly from the abovestated assumptions. It is recognized that an ASTC may provide a variety of services/Cases and that as a result the estimated average time and clean up and preparation time for such services/Cases may not meet the minimum numbers set forth herein. It is also recognized that an applicant applying for an ASTC Operating Room(s) may apply for a Procedure Room, although the anticipated utilization of that Procedure Room may not meet the base guidelines contained here. Specific reasoning and explanation for the inclusion in a CON application of such a Procedure Room must be provided. An applicant that desires to limit its Cases to a specific type or types should apply for a Specialty ASTC.

See Criterion 2d above. In Year Two of its operation, the replacement facility will average 2,164 cases per room, with 6 rooms. The applicant does not require exceptions to the criterion.

2. Need and Economic Efficiencies. An applicant must estimate the projected surgical hours to be utilized per year for two years based on the types of surgeries to be performed, including the preparation time between surgeries. Detailed support for estimates must be provided.

The following estimates are based on AmSurg's extensive experience operating and managing this type of facility. AmSurg operates the nation's largest system of endoscopy centers. These case times could vary, depending on the mix of low and high acuity cases.

#### *Year One (12,852 cases)*

25 minutes a. Average surgical time for endoscopy case:

b. Average room turnaround time: 10 minutes

35 minutes c. Total average minutes per case:

d. Available time in 6 procedure rooms:

60 minutes per hour X 8 hours per day X 250 days per year X 6 procedure rooms = 720,000 minutes of surgical room time available per year

e. Time required to perform Year Two projected volume of 12,852 cases: 12,852 cases X 35 total average minutes per case = 449,820 minutes required per year

f. Utilization or Occupancy Rate of Procedure Rooms =

449,820 minutes utilized / 720,000 minutes available =62.5% average utilization

#### Year Two (12,981 cases)

25 minutes a. Average surgical time for endoscopy case:

10 minutes b. Average room turnaround time:

35 minutes c. Total average minutes per case:

d. Available time in 6 procedure rooms:

60 minutes per hour X 8 hours per day X 250 days per year X 6 procedure rooms = 720,000 minutes of surgical room time available per year

e. Time required to perform Year One projected volume of 12,981 cases:

12,981 X 35 total average minutes per case = 454,335 minutes required per year

f. Utilization or Occupancy Rate of Procedure Rooms =

454,335 minutes utilized / 720,000 minutes available = 63.1% average utilization

3. Need; Economic Efficiencies; Access. To determine current utilization and need, an applicant should take into account both the availability and utilization of either: a) all existing outpatient Operating Rooms and Procedure Rooms in a Service Area, including physician office based surgery rooms (when those data are officially reported and available) OR b) all existing comparable outpatient Operating Rooms and Procedure Rooms based on the type of Cases to be performed. Additionally, applications should provide similar information on the availability of nearby out-of-state existing outpatient Operating Rooms and Procedure Rooms, if that data are available, and provide the source of that data. Unstaffed dedicated outpatient Operating Rooms and unstaffed dedicated outpatient Procedure Rooms are considered available for ambulatory surgery and are to be included in the inventory and in the measure of capacity.

In Sections B.II.C. above and C(I)5-6 below, the applicant has presented the publicly available data on utilization of 7 area providers that perform endoscopies (i.e., excluding eye surgery centers, plastic surgery centers, etc. which do not have gastroenterologists on staff; and excluding hospitals which do not report endoscopy cases.) In FYE 2014, the service area facilities that reported endoscopy utilization any year between FYE 2012 and FYE 2014 averaged 1,865 cases per procedure room-approximately the State Health Plan's optimal level of areawide utilization (1,867 per room). And by reducing the area's total procedure rooms, the project will increase average utilization per room, compared to what it would be if this project does not occur.

4. Need and Economic Efficiencies. An applicant must document the potential impact that the proposed new ASTC would have upon the existing service providers and their referral patterns. A CON application to establish an ASTC or to expand existing services of an ASTC should not be approved unless the existing ambulatory surgical services that provide comparable services regarding the types of Cases performed, if those services are know and relevant, within the applicant's proposed Service Area or within the applicant's facility are demonstrated to be currently utilized at 70% or above.

Not applicable. The project does not establish a facility; it only relocates an existing facility. It does not expand the facility in terms of its surgical services. The data provided in Section C(I)5-6 show that area facilities in FYE 2014 were utilized at 1,865 cases per procedure room, which for practical purposes equals the 70% criterion (1,867).

5. Need and Economic Efficiencies. An application for a Specialty ASTC should present its projections for the total number of cases based on its own calculations for the projected length of time per type of case, and shall provide any local, regional, or national data in support of its methodology. An applicant for a Specialty ASTC should provide its own definitions of the surgeries and/or procedures that will be performed and whether the Surgical Cases will be performed in an Operating Room or a Procedure Room. An applicant for a Specialty ASTC must document the potential impact that the proposed new ASTC would have upon the existing service providers and their referral patterns. A CON proposal to establish a Specialty ASTC or to expand existing services of a Specialty ASTC shall not be approved unless the existing ambulatory surgical services that provide comparable services regarding the types of Cases performed within the applicant's proposed Service Area or within the applicant's facility are demonstrated to be currently utilized at 70% or above. An applicant that is granted a CON for a Specialty ASTC shall have the specialty or limitation placed on the CON.

The applicant will perform only outpatient gastroenterology cases, to which it is currently limited. No change in that limitation is being requested. The applicant will perform these cases solely in procedure rooms. No operating rooms are available at the current location and none will be available at the new location. The other information requested in criterion #5 duplicates information already provided in response to criteria #2 and #4. Please see the applicant's responses to those criteria with respect to:

- Case time analysis based on applicant's own experience;
- Impact on other area facilities;
- Utilization data from other comparable facilities in the primary service area.

See also Section C(I)5 below for utilization of comparable facilities in the service area.

#### Other Standards and Criteria

6. Access to ASTCs. The majority of the population in a Service Area should reside within 60 minutes average driving time to the facility.

Complies. See drive time tables in Section B.III.B.1 above. The average drive time from major population centers in the service area is approximately 30 minutes.

7. Access to ASTCs. An applicant should provide information regarding the relationship of an existing or proposed ASTC site to public transportation routes if that information is available.

There is bus service available to the site. A Knoxville Area Transit (KAT) bus route map has been provided in Attachment C, Need--3.

- 8. Access to ASTCs. An application to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment center must
- project the origin of potential patients by percentage and county of residence and, if such data are readily available, by zip code, and
- must note where they are currently being served.
- Demographics of the Service Area should be included, including the anticipated provision of services to out-of-state patients, as well as
- the identity of other service providers both in and out of state and the source of out-of-state data. Applicants shall document all other provider alternatives available in the Service Area.
- All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.

<u>Patient Origin</u>: This is provided in Sections C(I)3-4. The primary service area will consist of Knox, Sevier, Jefferson, Blount, Anderson, and Hamblen Counties in East Tennessee. Zip code patient origin is not readily available.

<u>Places of Current Service</u>: The applicant does not project any significant negative impact on other facilities. The projected caseload at the new location is below what this facility experienced as recently as 2013, when Federal rules requiring ASTC's not to share space with physician practices compelled the facility to change to morning-only operation.

Demographics of the Service Area: This is provided in Section C(I)4.A.

Service Area Providers: The Tennessee Joint Annual Reports ("JARs") for Hospitals do not their number of endoscopies, or the endoscopies performed in the hospital's OR's vs. procedure rooms. The JAR's for Ambulatory Surgical Treatment Centers do state their numbers of endoscopy patients--but until FYE 2013 they did not report the utilization of total cases by OR's vs. procedure rooms. So unless the reporting facility is a single-specialty endoscopic surgery center, it is not possible to identify the procedure room utilization for just endoscopies. It is possible to identify procedure room utilization for all cases. The applicant has provided all available utilization data for all area surgery centers reporting endoscopy cases in Section C(I)5 below.

Assumptions--Each section's responses identifies its assumptions and sources of data.

9. Access and Economic Efficiencies. An application to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment center must project patient utilization for each of the first eight quarters following completion of

the project. All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.

Please see Section C(I)6 in the application. Quarterly breakdowns were distributed approximately evenly.

	Table Five: The Endoscopy Center Projection of Quarterly Cases, Years One and Two					
	O1 Cases Q2 Cases Q3 Cases Q4 Cases Total					
2017	3,213	3,213	3,213	3,213	12,852	
2018	3,245	3,245	3,245	3,246	12,981	

#### 10. Patient Safety and Quality of Care; Health Care Workforce.

a. An applicant should be or agree to become accredited by any accrediting organization approved by the Centers for Medicare and Medicaid Services, such as the Joint Commission, the Accreditation Association of Ambulatory Health Care, the American Association for Accreditation of Ambulatory Surgical Facilities, or other nationally recognized accrediting organization.

The applicant is already AAAHC-accredited and is committed to maintaining its accreditation.

b. An applicant should estimate the number of physicians by specialty that are

expected to utilize the facility and the criteria to be used by the facility in extending surgical and anesthesia privileges to medical personnel. An applicant should provide documentation on the availability of appropriate and qualified staff that will provide ancillary support services, whether on- or off-site.

The medical staff consists of 12 (soon to be 13) gastroenterologists. Their Board status is provided in Attachment C-Need--1.A.3. The facility requires that physicians applying for surgical or anesthesia privileges be Board-certified or Board-eligible in their appropriate specialties, along with other customary criteria.

- 11. Access to ASTCs. In light of Rule 0720-11.01, which lists the factors concerning need on which an application may be evaluated, and Principle No. 2 in the State Health Plan, "Every citizen should have reasonable access to health care," the HSDA may decide to give special consideration to an applicant:
- a. Who is offering the service in a medically underserved area as designated by the United States Health Resources and Services Administration;

The primary service area consists of Knox, Sevier, Jefferson, Blount, Anderson, and Hamblen Counties. Parts of this area are designated as medically underserved areas. They are identified in Attachment C-Need-1.A.

b. Who is a "safety net hospital" or a "children's hospital" as defined by the Bureau of TennCare Essential Access Hospital payment program;

Not applicable.

c. Who provides a written commitment of intention to contract with at least one TennCare MCO and, if providing adult services, to participate in the Medicare program;

The applicant so commits. The applicant already contracts with Medicare, and with three of the four TennCare MCO's in the area. The applicant is awaiting acceptance of a contract by the fourth MCO.

d. Who is proposing to use the ASTC for patients that typically require longer preparation and scanning times. The applicant shall provide in its application information supporting the additional time required per Case and the impact on the need standard.

Not applicable. The applicant's case times are not longer than the criteria.

## Project-Specific Review Criteria: Construction, Renovation, Expansion, and Replacement of Health Care Institutions

1. Any project that includes the addition of beds, services, or medical equipment will be reviewed under the standards for those specific activities.

Not applicable; none of these changes is being proposed.

- 2. For relocation or replacement of an existing licensed healthcare institution:
- a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

The applicant has provided detailed cost projections for relocation to a new site. Providing plans and budgets for "renovation" is not possible because the facility's current location is merged with a private group medical practice and there is no space into which the ASTC can expand by renovation to provide appropriate pre-op, recovery, and other support spaces.

b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

This is an existing facility. Its FYE 2013 utilization was reduced by 26% in CY2015 by having to cease operation as an ASTC in the afternoons. The cases projected for the first two years of this project are still below what these physicians received as referrals in 2013 when they had capacity in the ASTC to accept those referrals.

- 3. For renovation or expansion of an existing licensed healthcare institution:
- a. The applicant should demonstrate that there is an acceptable existing demand for the proposed project.
- b. the applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.

Not applicable; this is a replacement project and not a renovation or expansion project.

# The Framework for Tennessee's Comprehensive State Health Plan

Five Principles for Achieving Better Health

The following Five Principles for Achieving Better Health serve as the basic framework for the State Health Plan. After each principle, the applicant states how this CON application supports the principle, if applicable.

## 1. Healthy Lives

The purpose of the State Health Plan is to improve the health of Tennesseans. Every person's health is the result of the interaction of individual behaviors, society, the environment, economic factors, and our genetic endowment. The State Health Plan serves to facilitate the collaboration of organizations and their ideas to help address health at these many levels.

The project represents the collaboration of a major gastroenterology group practice with the nation's largest operator of endoscopic ambulatory surgical treatment centers, pairing medical expertise with management skills to foster continuous quality improvement and significant cost controls.

#### 2. Access to Care

Every citizen should have reasonable access to health care. Many elements impact one's access to health care, including existing health status, employment, income, geography, and culture. The State Health Plan can provide standards for reasonable access, offer policy direction to improve access, and serve a coordinating role to expand health care access.

The project pays careful attention to accessibility, both from financial and physical perspectives. The applicant has contracts with three of the four TennCare MCO's now operating Statewide; and is seeking a contract with the fourth MCO. The proposed site is very physically accessible to the service area counties in terms of drive time.

#### 3. Economic Efficiencies

The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies and the continued development of the state's health care system. The State Health Plan should work to identify opportunities to improve the efficiency of the state's health care system and to encourage innovation and competition.

The project will provide an efficient facility for the delivery of care, one which conforms to current codes and design standards. This will be done in a setting that costs Medicare approximately 30%-40% less than if the same surgeries were performed in a hospital or in a hospital-based outpatient department.

## 4. Quality of Care

Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers. Health care providers are held to certain professional standards by the state's licensure system. Many health care stakeholders are working to improve their quality of care through adoption of best practices and data-driven evaluation.

AmSurg Corp and the physician members of the applicant L.P. are committed to processes of continuous quality improvement and the delivery of cost-effective "best practices" medical care.

## 5. Health Care Workforce

The state should support the development, recruitment, and retention of a sufficient and quality health care workforce. The state should consider developing a comprehensive approach to ensure the existence of a sufficient, qualified health care workforce, taking into account issues regarding the number of providers at all levels and in all specialty and focus areas, the number of professionals in teaching positions, the capacity of medical, nursing, allied health and other educational institutions, state and federal laws and regulations impacting capacity programs, and funding.

The project has no significant impact on the healthcare workforce.

# C(I).2. DESCRIBE THE RELATIONSHIP OF THIS PROJECT TO THE APPLICANT'S LONG-RANGE DEVELOPMENT PLANS, IF ANY.

The Endoscopy Center (Knoxville) does not prepare long-range development plans.

C(I).3. IDENTIFY THE PROPOSED SERVICE AREA AND JUSTIFY THE REASONABLENESS OF THAT PROPOSED AREA. SUBMIT A COUNTY-LEVEL MAP INCLUDING THE STATE OF TENNESSEE CLEARLY MARKED TO REFLECT THE SERVICE AREA. PLEASE SUBMIT THE MAP ON A 8-1/2" X 11" SHEET OF WHITE PAPER MARKED ONLY WITH INK DETECTABLE BY A STANDARD PHOTOCOPIER (I.E., NO HIGHLIGHTERS, PENCILS, ETC.).

This is an existing facility whose relocation 1.4 miles away in the same city should not affect its patient origin. Table Six on the next page shows its patient origin by county and projects a similar patient origin for the relocated facility. The primary service area counties, from which approximately 82.1% of its patients came in CY2014, consisted of Knox, Sevier, Jefferson, Blount, Anderson, and Hamblen Counties. The projected origin of cases in CY 2017 and CY2018 should be the same.

Location maps and a map of the service area are provided in the Attachments to the application.

Table Six: The Patie	Endoscopy Ce nt Origin Proje CY2017-18	nter (Knoxvi ection			
County	Patients CY2014	Percent of Total Patients	Cumulative Percent of Total Patients	Year One CY2017 Cases	Year Two CY2018 Cases
Primary Service Area (PSA) Counties		04.00/	61.8%	7,939	8,018
Knox	5,190	61.8%		832	840
Sevier	544	6.5%			624
	404	4.8%	73.1%	618	456
Jefferson	295	3.5%	76.6%	451	
Blount	244	2.9%	79.5%	373	377
Anderson	222			340	343
Hamblen PSA Subtotal	6,899	82.1%			
Secondary Service Area (SSA) Counties and States	1,503	17.9%		2,299	2,322
Grand Total	8,402	100.0%		12,852	12,981

Source: Medical staff patient origin records and management projections.

# C(I).4.A DESCRIBE THE DEMOGRAPHICS OF THE POPULATION TO BE SERVED BY THIS PROPOSAL.

Table Seven on the next page provides the Tennessee Department of Health's projections that this service area's total population will increase by 4.6% from 2015 to 2019. This will be faster than the 32.7% rate of increase projected Statewide.

The population 50+ years of age is the cohort that most highly utilizes endoscopy services. That cohort in the service area is projected to increase 8.6% compared to a Statewide increase of 6.1%.

Median income in the primary service area is slightly less than Statewide. TennCare enrollment is lower at 17.8% than for the State as a whole, which is 21.0%. Approximately 16.4% of service area residents have annual incomes below the Federal poverty level, compared to 17.6% Statewide.

Table Seven: The Endoscopy Center (Knoxville) Demographic Characteristics of Primary Service Area
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Primary Service Area						De	Demographic Characteristics	Characteris	tics					
County	Median Age - 2010 Census	Total Population 2015	Total Population 2019	Total Population % Change 2015 - 2019	Total Population Age 50+ 2015	% of Population	Total Population Age 50+ 2019	% of Population	Age 50+ Population % of - Change	Median Household Income	TennCare Enrollees Apr 2015	Percent of 2015 Population Enrolled in TennCare	Persons Below Poverty Level	Persons Below Poverty Level as % of Population US Census
Anderson	42.6	76,949	78,123	1.5%	32,906	42.8%	34,458	44.1%	4.7%	\$43,620	15,946	20.7%	5,989	18.2%
Blount	41.4	129,973	137,058	5.5%	51,476	39.6%	55,032	40.2%	%6.9	\$45,991	21,570	16.6%	7,052	13.7%
Hamblen	39.6	64,438	65,952	2.3%	23,925	37.1%	24,766	37.6%	3.5%	\$39,596	15,217	23.6%	4,594	19.2%
Jefferson	40.8	54,482	22,707	2.9%	21,466	39.4%	23,096	40.0%	7.6%	\$39,745	11,841	21.7%	3,928	18.3%
Knox	37.2	459,124	481,044	4.8%	164,888	35.9%	183,248	38.1%	11.1%	\$47,694	73,127	15.9%	24,074	14.6%
Sevier	40.9	96,116	101,929	6.0%	37,704	39.5%	40,422	39.7%	7.2%	\$43,649	18,970	19.7%	5,467	14.5%
Tennessee PSA	40.4	881,082	921,813	4.6%	332,365	37.7%	361,022	39.5%	8.6%	\$43,383	156,671	17.8%	51,104	16.4%
State of Tennessee	38.0	6,649,438	6,894,997	3.7%	2,346,357	35.3%	2,490,254	36.1%	6.1%	\$44,298	1,399,004	21.0%	1,170,301	17.6%

Sources: TDH Population Projections, May 2013; U.S. Census QuickFacts; TennCare Bureau Apr 2015. PSA data is unweighted average, or total, of county data.

C(I).4.B. DESCRIBE THE SPECIAL NEEDS OF THE SERVICE AREA POPULATION, INCLUDING HEALTH DISPARITIES, THE ACCESSIBILITY TO CONSUMERS, PARTICULARLY THE ELDERLY, WOMEN, RACIAL AND ETHNIC MINORITIES, AND LOW-INCOME GROUPS. DOCUMENT HOW THE BUSINESS PLANS OF THE FACILITY WILL TAKE INTO CONSIDERATION THE SPECIAL NEEDS OF THE SERVICE AREA POPULATION.

The need for periodic screening and other endoscopies is now considered universal for all persons 50 years of age and older (45 years of age or older for African-Americans), in order to prevent avoidable deaths from colon cancer. This is a need shared by all, regardless of gender, race, ethnicity, or income level.

The Endoscopy Center is open to all of the above groups. It contracts with three of Tennessee's TennCare plans, and will be contracted to a fourth plan in the near future. For persons without adequate insurance, discounting and periodic payment plans are worked out individually prior to service, with eligibility based on income. Charitable discounts were calculated for the Historic and Projected Data Charts in this application.

C(I).5. DESCRIBE THE EXISTING OR CERTIFIED SERVICES, INCLUDING APPROVED BUT UNIMPLEMENTED CON'S, OF SIMILAR INSTITUTIONS IN THE SERVICE AREA. INCLUDE UTILIZATION AND/OR OCCUPANCY TRENDS FOR EACH OF THE MOST RECENT THREE YEARS OF DATA AVAILABLE FOR THIS TYPE OF PROJECT. BE CERTAIN TO LIST EACH INSTITUTION AND ITS UTILIZATION AND/OR OCCUPANCY INDIVIDUALLY. INPATIENT BED PROJECTS MUST INCLUDE THE FOLLOWING DATA: ADMISSIONS OR DISCHARGES, PATIENT DAYS, AND OCCUPANCY. OTHER PROJECTS SHOULD USE THE MOST APPROPRIATE MEASURES, E.G., CASES, PROCEDURES, VISITS, ADMISSIONS, ETC.

In the project's primary service area, there are 7 ambulatory surgical treatment centers whose Joint Annual Reports indicate that they performed outpatient endoscopies during one or more of the past three reporting years (FYE's ending June 30). Their utilization for those years is shown in Table Eight-A on the following page. Table Eight-B on the second following page shows these providers' cases by procedure room and operating room, for FYE 2013-14, the only two years for which such JAR data is available. Utilization per procedure room increased 8.2% from FYE 2013 to FYE 2014.

	Table Eight-A: The Endoscopy Center (Knoxville)	Endos	copy Cente	r (Knoxvi	lle)			
	Primary Service Area Utilization of Ambulatory Surgical Treatment Centers Performing Endoscopies	ry Sur	gical Treat	nent Cen	ters Perf	orming En	doscopies	
			N C					
	2012 Joint Annual Report of ASTC's							
				Total Surgical	Total	Cases Per Surgical	GI Endoscopy	GI Endoscopy Cases Percent
County	Facility Name	O.R.'s	Rooms	Rooms	Cases	Room	Cases	of Total Cases
Knox	Children's West Surgery Center	3	0	ĸ	3,900		165	_
	Fort Sanders West Surgery Center	4		4	1,616		0	
	Parkwest Surgery Center	5		9	4.681			
	The Endoscopy Center	0		o	9 421	-	1010	100
	The Endoscopy Center North	C	0	0 0	A 116		7,421	
	The Endoscopy Center West			1 (	2 045		4,110	
Blount	Tennessee Endoscopy Center			7 6	5 5/13		2,945	100.0%
	PRIMARY SERVICE AREA	1,	,	000	240,0		3,343	
	TRIVIANI SENVICE AREA		QT	87	37,777	1,151	22,190	68.9%
		I						
	2013 Joint Annual Report of ASTC's							
				Total		Cases Per		GI Endoscopy
1			Procedure	Surgical	Total	Surgical	GI Endoscopy	Cases Percent
County	Facility Name	O.R. 's	Rooms	Rooms	Cases	Room	Cases	of Total Cases
Knox	Children's West Surgery Center	3	0	c	4,125	1,375	172	4.2%
	Fort Sanders West Surgery Center	4	0	4	3,523	881	0	0.0%
	Parkwest Surgery Center	5	1	9	4,775	796	0	0.0%
	The Endoscopy Center	0	8	8	11,788	1,474	11,788	100.0%
	The Endoscopy Center North	0	2	2	4,816	2,408	4,816	100.0%
		0	2	2	3,749	1,875	3,749	100.0%
Blount	Tennessee Endoscopy Center	0	3	3	7,012	2,337	7,012	100.0%
	PRIMARY SERVICE AREA	12	16	28	39,788	1,421	27,537	69.2%
							***************************************	
	2014 Joint Annual Report of ASTC's							
				Total		Cases Per		GI Endoscopy
County	Facility Name	0	Procedure	Surgical	Total	Surgical	GI Endoscopy	Cases Percent
Knov	Children's Wort Current Control	2.5	ROOMS	Kooms	Cases	Koom	Cases	of Total Cases
YOUN	Eart Cardon Most Current	ν,	0	20	4,569	1,523	184	4.0%
	I o'r saineis west suigery center	4	٥	4	2,003	501	137	%8.9
	Parkwest Surgery Center	Ŋ	1	9	5,343	891	0	0.0%
	The Endoscopy Center	0	∞	8	9,953	1,244	9,953	100.0%
	The Endoscopy Center North	0	2	2	6,237	3,119	6,237	100.0%
	The Endoscopy Center West	0	2	2	4,929	2,465	4,929	100.0%
Blount	Tennessee Endoscopy Center	0	3	3	7,081	2,360	7,012	80.66
	PRIMARY SERVICE AREA	12	16	28	40,115	1,433	28.452	%6.07
		Ī						

Source: Joint Annual Reports, FYE 2012-2014.

Table Eight-B:

FYE 2013-2014 Utilization of Endoscopy ASTC Providers By Type of Room

(Unavailable in the Joint Annual Report Before FYE 2013)

	701 5207 1	FYE 20	14	. Dulm aug	Somvine A	rog
ASTC'S Perform	ning End	loscopies in	roject	s Primary	Sel vice A	Ita
			FY C	ases in		
			Ope	rating		ases in
			Ro	oms	Procedu	re Rooms
				FY		
		Procedure	FY	Cases	FY	FY Cases
ASTC Name	OR's	Rooms	Cases	Per OR	Cases	Per Room
KNOX COUNTY					-	0
Children's West Surg. Cntr.	3	0	4,569	1,523	0	0
Ft .Sanders W. Surg. Center	4	0	2,003	501	0	
Parkwest Surgery Center	5	1	3,704	741	1,639	1,639
The Endoscopy Center	0	8	0	0	9,953	1,244
The Endoscopy Center N.	0	2	0	0	6,237	3,119
The Endoscopy Center W.	0	2	0	0	4,929	2,465
BLOUNT COUNTY					= 0.01	2.260
Tennessee Endoscopy Cntr.	0	3	0	0	7,081	2,360
Service Area Totals	12	16	10,276	856	29,839	1,865

		FYE 20	13			
ASTC'S Perfor	ming En	doscopies in	Project	's Primary	Service .	Area
ASIC SIGNA		•	FY C	ases in		
			Ope	rating	FY C	cases in
			Ro	oms	Procedu	re Rooms
				FY		
	1	Procedure	FY	Cases	FY	FY Cases
ASTC Name	OR's	Rooms	Cases	Per OR	Cases	Per Room
KNOX COUNTY						
Children's West Surg. Cntr.	3	0	4,125	1,375	0	0
Ft .Sanders W. Surg, Center	4	0	3,523	881	0	0
Parkwest Surgery Center	5	1	3,960	792	815	815
The Endoscopy Center	0	8	0	0	11,788	1,250
The Endoscopy Center N.	0	2	0	0	4,816	2,120
The Endoscopy Center W.	0	2	0	0	3,749	634
BLOUNT COUNTY					7.012	2,337
Tennessee Endoscopy Cntr.	0	3	0	0	7,012	2,337
Service Area Totals	12	16	11,608	967	27,565	1,723

Source: Joint Annual Reports page 7 Schedule D, as amended by applicant 7-15.

PROVIDE APPLICABLE UTILIZATION AND/OR OCCUPANCY C(I).6. STATISTICS FOR YOUR INSTITUTION FOR EACH OF THE PAST THREE (3) YEARS AND THE PROJECTED ANNUAL UTILIZATION FOR EACH OF THE FOLLOWING COMPLETION OF THE TWO (2) YEARS **DETAILS** REGARDING **PROVIDE** THE ADDITIONALLY. **PROJECT** UTILIZATION. THE **USED** TO METHODOLOGY MUST INCLUDE DETAILED CALCULATIONS OR METHODOLOGY DOCUMENTATION FROM REFERRAL SOURCES, AND IDENTIFICATION OF ALL ASSUMPTIONS.

The historical and projected utilization for The Endoscopy Center (Knoxville) is shown in Table Three-A below.

Historically, The Endoscopy Center on Weisgbarber Road in Knoxville was one of the earliest endoscopic ambulatory surgery centers developed in Tennessee. It opened in 1986, almost three decades ago. It was also the Knoxville region's largest ASTC provider of outpatient endoscopic cases until July of 2013. In the fiscal year ending June 2013, of the seven area ASTC's who performed endoscopic cases, The Endoscopy Center performed almost 30% of all those cases and performed 64% more cases than the next-highest provider.

Between 2010 and 2013, Medicare directed surgery centers nationwide to cease all space-sharing arrangements with adjoining physician practice offices. Up to that time, it was commonplace--and very economical--for surgery centers to share areas such as reception, waiting, and business with the physician group practices that constituted their medical staffs. The Endoscopy Center shared some spaces with its associated medical practice, Gastrointestinal Associates ("GIA").

Threatened with loss of Medicare reimbursement, but with no expansion room available in its Weisgarber Road building, and with lease commitments, The Endoscopy Center's only way to comply with Medicare's new space-sharing prohibition was to negotiate a temporary time-sharing agreement with the medical practice (GIA), that was acceptable to Medicare and to State Licensure. The agreement gave the Center exclusive use of the entire premises from 7 AM to noon daily, with GIA using the entire premises exclusively as a gastroenterology group practice office during the afternoons. This operational arrangement is still in effect.

The sudden reduction of *effective* surgical capacity by a required closure at noon, and the death of the center's busiest surgeon (who performed approximately 1,500 cases per year), caused the center's utilization to decline the following year by 15%--from 11,251 cases in CY2013 to a projected 9,560 cases in CY2015. With additional physician recruitment since 2013, utilization is slowly increasing, but the limitation to half-day operation is a severe restraint on case referrals to this practice and to its ASTC.

The facility's annualized CY2015 utilization based on January-June is 9,560 cases. In CY2016, at the current location, facility management projects that normal growth in physician referrals will increase utilization by at least 1%, to 9,656 cases. In CY2017, even at the current location, normal growth brought by existing medical staff will again increase utilization by 1%, to 9,752 cases.

But if the proposed relocation is approved, allowing normal full-day operation, an *additional* 3,100 new cases will be brought to the new location in CY2017 by two physicians who currently do not have room to perform their cases at this facility. Dr. Jeff Gilbert, an established Anderson County gastroenterologist, is joining the Center in late 2015. He projects bringing 2,200 of his current cases to the new location in CY2017-600 cases currently being performed at two Knox County endoscopy centers owned by this same applicant, plus 300 new cases from normal practice growth between 2015 and 2017. Dr. Gilbert's and Dr. Moore's letter attesting to these new cases are provided in the Attachments.

In CY2017, with a normal full-day surgical schedule resumed at the new location, and with Dr. Gilbert and Dr. Moore's transferred cases, The Endoscopy Center projects a first-year caseload of 12,852 cases. The following year the Center projects a continuing 1% increase in utilization, to 12,981 cases.

Table Three-A below shows that the projected occupancy on the proposed facility is consistent with the Guidelines of the State Health Plan. The Table shows surgical room utilization as a percent of three standards: (a) Amsurg's broad general goal of performing 2,500 cases per room; (b) the State Health Plan's "optimal" goal of 1,867

cases per room (70% occupancy); and (c) the State Health Plan's definition of 100% occupancy for a procedure room.

The project will operate in Year Two (2018) at approximately 116% of the State Health Plan's optimal efficiency standard. It will operate at 86.6% of AmSurg's own higher expectation for this type of facility.

		ıd Project		copy Center (Knotion 2012-2018 ( Cases		
Calendar Year	Procedure Rooms	Cases	Cases Per Room	Percent of AmSurg Optimal Cases of 2,500 / Rm	Percent of State Health Plan Optimal Cases of 1,867 / Rm	Percent of State Health Plan Full Capacity Cases of 2,667 / Rm
(Historical)						
CY 2012	8	11,462	1,433	57.3%	76.8%	53.7%
CY 2013	8	11,251	1,406	56.2%	75.3%	52.7%
CY 2014	8	9,652	1,207	48.3%	64.6%	45.3%
(Projected)						
CY 2015	8	9,560	1,195	47.8%	64.0%	44.8%
CY 2016	8	9,656	1,207	48.3%	64.7%	45.3%
CY 2017-Yr 1	6	12,852	2,142	85.7%	114.7%	80.3%
CY 2018-Yr 2	6	12,981	2,164	86.6%	115.9%	81.1%

Sources: FY2012-15 historical cases from AmSurg management and facility records; 2015 annualized on Jan-June. CY2016-18 projected cases from AmSurg management.

Converting this utilization into room need, Table Three-B below shows the procedure rooms that the projected utilization needs under AmSurg's and the State Health Plan's standards. Under the State Health Plan's optimal occupancy standard, seven procedure rooms will be needed in CY2018, Year Two. AmSurg's standard indicates that with a need for 5.2 procedure rooms, 6 rooms will be appropriate and will provide room for future growth. Consistent with that, 6 rooms are being proposed in this application. That will be a decrease of 2 rooms from the current 8-room license.

Pr	Table Three ocedure Room N	-B: The Endos Need Based on A Utilization S	AmSurg and	(Knoxville) State Health Pl	an
Year	Procedure Rooms	Cases	Cases Per Room	Room Need At AmSurg Goal of 2500 Cases Per Room	Room Need At State Health Plan Optimal Standard of 1,867 Cases Per Room
(Historical)					
CY 2012	8	11,462	1,433	4.6	6.1
CY 2013	8	11,251	1,406	4.5	6.0
CY2014	8	9,652	1,207	3.9	5.2
(Projected)					
CY 2015 Ann'd	8	9,560	1,195	3.8	5.1
CY 2016	8	9,656	1,207	3.9	5.2
CY 2017-Yr 1	6	12,852	2,142	5.1	6.9
CY 2018-Yr 2	6	12,981	2,164	5.2	7.0

Source: Table Three-A.

C(II)1. PROVIDE THE COST OF THE PROJECT BY COMPLETING THE PROJECT COSTS CHART ON THE FOLLOWING PAGE. JUSTIFY THE COST OF THE PROJECT.

- ALL PROJECTS SHOULD HAVE A PROJECT COST OF AT LEAST \$3,000 ON LINE F (MINIMUM CON FILING FEE). CON FILING FEE SHOULD BE CALCULATED ON LINE D.
- THE COST OF ANY LEASE (BUILDING, LAND, AND/OR EQUIPMENT) SHOULD BE BASED ON FAIR MARKET VALUE OR THE TOTAL AMOUNT OF THE LEASE PAYMENTS OVER THE INITIAL TERM OF THE LEASE, WHICHEVER IS GREATER. NOTE: THIS APPLIES TO ALL EQUIPMENT LEASES INCLUDING BY PROCEDURE OR "PER CLICK" ARRANGEMENTS. THE METHODOLOGY USED TO DETERMINE THE TOTAL LEASE COST FOR A "PER CLICK" ARRANGEMENT MUST INCLUDE, AT A MINIMUM, THE PROJECTED PROCEDURES, THE "PER CLICK" RATE AND THE TERM OF THE LEASE.
- THE COST FOR FIXED AND MOVEABLE EQUIPMENT INCLUDES, BUT IS NOT NECESSARILY LIMITED TO, MAINTENANCE AGREEMENTS COVERING THE EXPECTED USEFUL LIFE OF THE EQUIPMENT; FEDERAL, STATE, AND LOCAL TAXES AND OTHER GOVERNMENT ASSESSMENTS; AND INSTALLATION CHARGES, EXCLUDING CAPITAL EXPENDITURES FOR PHYSICAL PLANT RENOVATION OR IN-WALL SHIELDING, WHICH SHOULD BE INCLUDED UNDER CONSTRUCTION COSTS OR INCORPORATED IN A FACILITY LEASE.
- FOR PROJECTS THAT INCLUDE NEW CONSTRUCTION, MODIFICATION, AND/OR RENOVATION; DOCUMENTATION MUST BE PROVIDED FROM A CONTRACTOR AND/OR ARCHITECT THAT SUPPORT THE ESTIMATED CONSTRUCTION COSTS.

The architect's letter supporting the construction cost estimate is provided in Attachment C, Economic Feasibility--1.

On the Project Costs Chart, following this response:

Line A.1, A&E fees, were estimated by the project architect.

Line A.2, legal, administrative, and consultant fees, include a contingency for expenses of legal counsel in the event of opposition.

Line A.5, construction cost, was calculated by AmSurg development staff. Please note that this is the build-out cost for the CON applicant, in leased space. It does not include the developer's building cost, which is taken into account in the Chart under Section B.1 (see below for explanation).

Line A.6, contingency, was estimated at 10% of the applicant's construction cost in line A.5.

Line A.8 includes both fixed and moveable equipment costs, estimated by AmSurg development staff.

Line B.1 is the fair market value of the facility being leased. It was calculated in the two alternative ways required by HSDA rules. The lease outlay was the larger of these two alternative calculations and was used in Line B.1. The calculations were:

Lease Outlay Method: The lease option states the terms of the future lease. Its first term will be 15 years. The leasable area will be 17,173 rentable SF. The base lease rate will be \$25.00 PSF in Year One, escalating 1% annually for the next 14 years. The total of first term lease payments will be \$6,910,800.

Building Value Method: The developer provided complete capital cost data for acquisition and development of the site and the shell building. The total cost incurred by the developer to deliver a leasable shell building was estimated at \$11,414,000. The developer has allocated to the ASTC floor a total capital cost of \$4,037,000--which under CON rules would be the fair market value of the shell floor that the CON applicant will lease.

Line C.1, interim financing, was estimated as follows: (Part A + Part E costs) X 1/2 (average balance) X 5% interest X 1 year = \$167,827.

## PROJECT COSTS CHART--THE ENDOSCOPY CENTER OF KNOXVILLE

A.	Construction and equipment acquired by purchase:		
	<ol> <li>Architectural and Engineering Fees</li> <li>Legal, Administrative, Consultant Fees (Excl Consultant Fees)</li> <li>Acquisition of Site</li> <li>Preparation of Site</li> <li>Construction Cost 16,732 SF @ \$257 PSF</li> <li>Contingency Fund 10% of A.5</li> <li>Fixed Equipment (Not included in Construction Moveable Equipment (List all equipment over Section A.5)</li> <li>Other (Specify) misc. fees in A.5</li> </ol>	Contract)	283,007 50,000 0 4,300,124 430,012 0 1,618,987 0
В.	Acquisition by gift, donation, or lease:		
	<ol> <li>Facility (inclusive of building and land)</li> <li>Building only</li> <li>Land only</li> <li>Equipment (Specify)</li> <li>Other (Specify)</li> </ol>		6,910,800 0 0 0
C.	Financing Costs and Fees:		
	<ol> <li>Interim Financing</li> <li>Underwriting Costs</li> <li>Reserve for One Year's Debt Service</li> <li>Other (Specify)</li> </ol>	9 9 	167,827 0 0
D.	Estimated Project Cost (A+B+C)		13,760,757
E.	CON Filing Fee		30,962
F.	Total Estimated Project Cost (D+E)	TOTAL \$	13,791,719
		Actual Capital Cost Section B FMV	6,880,919 6,910,800
		7 E0/ v 1 vm	

Interim Interest: ( A + E) X 1/2 avg balance X 5% x 1 yr (\$6,682,130 + \$30,962 fee before this calculation) X .5 X .05 X 1 = \$167,827

## C(II).2. IDENTIFY THE FUNDING SOURCES FOR THIS PROJECT.

FINANCED. **PROJECT** WILL BE HOW THE SUMMARIZE (DOCUMENTATION FOR THE TYPE OF FUNDING MUST BE INSERTED AT THE END OF THE APPLICATION, IN THE CORRECT ALPHANUMERIC ORDER AND IDENTIFIED AS ATTACHMENT C, ECONOMIC FEASIBILITY--2). x A. Commercial Loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions; B. Tax-Exempt Bonds--copy of preliminary resolution or a letter from the issuing authority, stating favorable contact and a conditional agreement from an

a. PLEASE CHECK THE APPLICABLE ITEM(S) BELOW AND BRIEFLY

\_\_\_\_\_C. General Obligation Bonds--Copy of resolution from issuing authority or minutes from the appropriate meeting;

\_\_\_\_\_D. Grants--Notification of Intent form for grant application or notice of grant award;

\_\_\_\_E. Cash Reserves--Appropriate documentation from Chief Financial Officer; or

F. Other--Identify and document funding from all sources.

underwriter or investment banker to proceed with the issuance;

The project will be funded AmSurg Corp, which will loan to the applicant LLC the full actual capital expenses of the project--currently estimated at slightly less than \$6,883,000. The availability of this financing is documented in Attachment C, Economic Feasibility--2, with a letter from the Chief Financial Officer of AmSurg. An amortization schedule that states the amount and terms of the loan is attached to that letter.

C(II).3. DISCUSS AND DOCUMENT THE REASONABLENESS OF THE PROPOSED PROJECT COSTS. IF APPLICABLE, COMPARE THE COST PER SQUARE FOOT OF CONSTRUCTION TO SIMILAR PROJECTS RECENTLY APPROVED BY THE HSDA.

The HSDA has calculated 2012-2014 ASTC construction cost averages for approved projects. However, there were too few samples to calculate renovation or new construction costs separately.

A	mbulatory Surgery Cent Years: 2	er Construction ( 012-2014	Cost PSF
	Renovated Construction	New Construction	Total Construction
1 <sup>st</sup> Quartile	\$0/sq ft	\$0/sq ft	\$113.55/sq ft
Median	\$0/sq ft	\$0/sq ft	\$150.00/sq ft
3 <sup>rd</sup> Quartile	\$0/sq ft	\$0/sq ft	\$174.88/sq ft

Source: HSDA Registry; CON approved applications for years 2012 through 2014

However, surgery center construction projects approved by the HSDA in 2011-2013 had the following construction costs per SF:

Ambula	ntory Surgery Cent Years: 2	ter Construction 011-2013	Cost PSF
	Renovated	New	Total
	Construction	Construction	Construction
1 <sup>st</sup> Quartile	\$95.04/sq ft	\$174.88/sq ft	\$113.55/sq ft
Median	\$113.55/sq ft	\$223.62/sq ft	\$162.00/sq ft
3 <sup>rd</sup> Quartile	\$150.00/sq ft	\$269.76/sq ft	\$223.62/sq ft

Source: HSDA Registry; CON approved applications for years 2011 through 2013

The applicant's build-out (renovation) cost of \$257 PSF is above the HSDA's last calculated average third quartile cost for ASTC's. But this is reasonable due to the steady annual increase in construction costs since 2011, and the costs in the Knoxville market for such projects. The construction will be paid for in 2016, which is four years beyond the midpoint of the HSDA 2011-13 range.

Table Tw	o-B (Repeated): Co	onstruction Costs of Th	is Project
	Applicant's Renovation	Applicant's New Construction	Applicant's Total Construction
Square Feet	16,732 SF	0	16,732 SF
Construction Cost	\$4,300,124	0	\$4,300,124
Constr. Cost PSF	\$257 PSF	0	\$257 PSF

C(II).4. COMPLETE HISTORICAL AND PROJECTED DATA CHARTS ON THE FOLLOWING TWO PAGES--DO NOT MODIFY THE CHARTS PROVIDED OR SUBMIT CHART SUBSTITUTIONS. HISTORICAL DATA CHART REPRESENTS REVENUE AND EXPENSE INFORMATION FOR THE LAST THREE (3) YEARS FOR WHICH COMPLETE DATA IS AVAILABLE PROJECTED DATA CHART REQUESTS FOR THE INSTITUTION. INFORMATION FOR THE TWO YEARS FOLLOWING COMPLETION OF PROJECTED DATA CHART SHOULD INCLUDE THIS PROPOSAL. REVENUE AND EXPENSE PROJECTIONS FOR THE PROPOSAL ONLY (I.E., FOR ADDITIONAL BEDS, **INCLUDE** APPLICATION IS ANTICIPATED REVENUE FROM THE PROPOSED BEDS ONLY, NOT FROM ALL BEDS IN THE FACILITY).

See the following pages for these charts, with notes where applicable. Please note that these charts and this application use calendar year data rather than the fiscal year (FYE June 30) data in the ASTC Joint Annual Reports.

## ${\bf HISTORICAL\ DATA\ CHART--THE\ ENDOSCOPY\ CENTER\ (KNOXVILLE)}$

Give information for the last three (3) years for which complete data are available for the facility or agency. The fiscal year begins in January.

THE	Cases		Year 2012 11462		Year 2013 11251		Year 2014 9652
Α.	Utilization Data						
В.	Revenue from Services to Patients						
	1. Inpatient Services	\$		_			
	2. Outpatient Services		18,736,599		20,400,296		17,454,957
	3. Emergency Services	-	10				
	4. Other Operating Revenue						
	(Specify) See notes page		//.	0	,;		
	Gross Operating Revenue	\$_	18,736,599	\$	20,400,296	\$_	17,454,957
C.	Deductions for Operating Revenue	×=					
	1. Contractual Adjustments	\$_	12,437,647	_	14,100,654	_	12,064,650
	2. Provision for Charity Care		77,155	_	127,989	-	94,302
	3. Provisions for Bad Debt		193,001		64,813		122,883
	Total Deductions	\$_	12,707,803	\$_	14,293,456	\$	12,281,835
NET	OPERATING REVENUE	\$_	6,028,796	\$_	6,106,840	\$_	5,173,122
D.	Operating Expenses						0.407.000
	1. Salaries and Wages	\$_	2,755,690	_	2,878,240	300	2,407,309
	<ol><li>Physicians Salaries and Wages</li></ol>	_		_		-	100.010
	3. Supplies	-	534,447	,,	581,418	-	480,012
	4. Taxes	-	166,741	-	186,119	_	174,364
	5. Depreciation		296,698	-	238,173	-	231,163
	6. Rent		154,924	_	155,824	-	152,789
	7. Interest, other than Capital	_	213	_	(120)	-	(449)
	8. Management Fees			_		-	
	a. Fees to Affiliates		50,000	=	50,000	12	50,000
	b. Fees to Non-Affiliates					-	
	9. Other Expenses (Specify) See notes page	_	926,372	_	887,090	-	774,611
	Total Operating Expenses	\$_	4,885,085		4,976,744		4,269,799
E.	Other Revenue (Expenses) Net (Specify)	\$_		\$_		\$_	
NET	OPERATING INCOME (LOSS)	\$_	1,143,711	\$_	1,130,096	\$_	903,323
F.	Capital Expenditures				404440		1.40 550
	1. Retirement of Principal	\$_	175,184	\$_	194,119	\$_	149,556
	2. Interest		13,941	. =	8,203		2,316
	Total Capital Expenditures	\$_	189,125	\$_	202,322	\$_	151,872
	OPERATING INCOME (LOSS) S CAPITAL EXPENDITURES	\$_	954,586	\$_	927,774	\$_	751,451

# PROJECTED DATA CHART-- THE ENDOSCOPY CENTER (KNOXVILLE)

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January.

					CY 2017		CY 2018
A.	Utiliza	ation Data	Cases	-	12,852	:::	12,981
В.	Reve	nue from Services to Patients				Φ.	
	1.	Inpatient Services		\$_		\$_	22.046.194
	2.	Outpatient Services		_	23,474,349	-	23,946,184
	3.	Emergency Services				-	
	4.	Other Operating Revenue (Spec	See notes page	-			22.046.404
			<b>Gross Operating Revenue</b>	\$_	23,474,349	\$_	23,946,184
C.	Dedu	ictions for Operating Revenue					4 5 200 220
	1.	Contractual Adjustments		\$_	15,026,121	\$_	15,398,236
	2.	Provision for Charity Care		10	1,344,498	-	1,371,522
	3.	Provisions for Bad Debt		-	164,072	, de	167,370
			<b>Total Deductions</b>	\$_	16,534,691	\$_	16,937,128
NET	OPER	ATING REVENUE		\$_	6,939,659	\$	7,009,056
D.	Opei	rating Expenses				2.7	
	1.	Salaries and Wages		\$_	2,815,444	\$_	2,871,753
	2.	Physicians Salaries and Wages				+	0
	3.	Supplies			648,702		661,676
	4.	Taxes		-	220,741		225,156
	5.	Depreciation			631,955		631,955
	6.	Rent		-	470,027		479,428
	7.	Interest, other than Capital			(449)	- 6	(458)
	8.	Management Fees				9	0
		a. Fees to Affiliates		0.	50,000	: 19	51,000
		b. Fees to Non-Affiliates				0	0
	9.	Other Expenses (Specify)	See notes page		1,150,144		1,173,147
		Dues, Utilities, Insurance, and Prop Taxes.					
			<b>Total Operating Expenses</b>	\$	5,986,564	\$	6,093,656
E.	Oth	er Revenue (Expenses) Net (S	Specify)	\$		\$	
		RATING INCOME (LOSS)		\$	953,095	\$	915,399
F.	Cap	oital Expenditures			504.050	<b>ተ</b>	FF6 727
	1.	Retirement of Principal		\$	531,259	\$	
	2.	Interest			334,107	iii	306,945
			Total Capital Expenditures	\$	865,366	. \$	863,682
NE	T OPE	RATING INCOME (LOSS)			07 700		51,717
LE	SS CA	PITAL EXPENDITURES		\$	87,729	\$	31,717

## THE ENDOSCOPY CENTER (KNOXVILLE) D9--OTHER EXPENSES

	CY 2012	CY 2013	CY 2014
7301-0000 Linen service	45,805	45,564	53,187
7303-0000 Cleaning service	14,620	14,084	11,601
7305-0000 Medical waste	32,343	6,249	10,186
7306-0000 Medical specialist fee	18,000	18,000	18,000
7307-0000 Transcription service	5,969	2,957	3,176
7311-0000 Accounting fees related party	4,603	4,603	4,603
7312-0000 Outside accounting services	27,820	28,080	48,027
7313-0000 Legal fees	5€8	206	
7321-0000 Collection fees	24,908	22,396	25,657
7323-0000 Contract services	125,202	99,488	75,449
7327-0000 Uniform allowance	5,155	4,215	7,430
7329-0000 Patient transportation	-	14	-
7331-0000 GP travel	6,581	2,414	1,809
7333-0000 LP travel	11,608	10,593	14,246
7337-0000 Business meals and entertainment	9,266	11,413	3,190
7339-0000 Office supplies	98,750	94,940	69,968
7341-0000 Postage	23,377	20,908	20,190
7343-0000 Express delivery	758	951	1,045
7347-0000 Telephone	77,190	68,875	57,898
7349-0000 Dues and subscriptions	19,805	14,829	11,570
7351-0000 Meetings and conferences	1,923	7,234	11,211
7353-0000 Maintenance scopes	48,099	56,697	52,757
7355-0000 Maintenance other	68,908	62,797	45,434
7356-0000 Software maintenance contracts	69,520	114,468	95,945
7357-0000 Advertising	44,578	43,720	26,024
7361-0000 Donations and contributions		499	
7363-0000 Employee recruiting cost	13,491	11,205	41
7369-0000 Other operating expense	29,684	18,884	12,858
7371-0000 Accreditation fee	11,934	#2	
7415-0000 CAM	- 2	12,256	12,065
7421-0000 Insurance malpractice	23,837	22,722	18,099
7422-0000 Insurance other	11,033	13,702	14,170
7431-0000 Utilities	57,824	57,443	53,155
8109-0000 Miscellaneous other income	(9,341)	(5,304)	(4,378)
8109-0000 Miscellaneous	2,999		
TOTAL	\$926,248	\$887,091	\$774,611

HISTORIC DATA CHART

	PROJECTED DATA CHART		
	CY 2017	CY 2018	
7301-0000 Linen service	70,820	71,882	
7303-0000 Cleaning service	68,692	69,722	
7305-0000 Medical waste	13,563	13,766	
7306-0000 Medical specialist fee	18,000	18,270	
7307-0000 Transcription service	4,229	4,292	
7311-0000 Accounting fees related party	4,603	4,672	
7312-0000 Outside accounting services	31,200	31,668	
7313-0000 Legal fees	= = =	-	
7321-0000 Collection fees	34,163	34,675	
7323-0000 Contract services	100,463	101,970	
7327-0000 Uniform allowance	9,893	10,041	
7329-0000 Patient transportation			
7331-0000 GP travel	2,408	2,444	
7333-0000 LP travel	18,969	19,254	
7337-0000 Business meals and entertainme	4,247	4,311	
7339-0000 Office supplies	93,166	94,563	
7341-0000 Postage	26,884	27,287	
7343-0000 Express delivery	1,392	1,413	
7347-0000 Telephone	57,898	58,766	
7349-0000 Dues and subscriptions	11,570	11,744	
7351-0000 Meetings and conferences	11,211	11,379	
7353-0000 Maintenance scopes	70,248	71,302	
7355-0000 Maintenance other	62,797	63,739	
7356-0000 Software maintenance contracts	107,925	109,544	
7357-0000 Advertising	26,024	26,414	
7361-0000 Donations and contributions	-	-	
7363-0000 Employee recruiting cost	11,205	11,373	
7369-0000 Other operating expense	17,120	17,377	
7371-0000 Accreditation fee	11,934	12,113	
7415-0000 CAM	103,038	104,584	
7421-0000 Insurance malpractice	24,100	24,462	
7422-0000 Insurance other	18,000	18,270	
7431-0000 Utilities	120,211	122,014	
8109-0000 Miscellaneous other income	(5,829)	(5,916)	
8109-0000 Miscellaneous other income			
TOTAL	\$1,150,144	\$1,167,396	

C(II).5. PLEASE IDENTIFY THE PROJECT'S AVERAGE GROSS CHARGE, AVERAGE DEDUCTION FROM OPERATING REVENUE, AND AVERAGE NET CHARGE.

Table Nine: The Endoscopy Center (Knoxville) Average Charges, Deductions, and Net Charges					
	CY2017	CY2018			
Cases	12,852	12,981			
Average Gross Charge Per Case	\$1,827	\$1,845			
Average Deduction Per Case	\$1,287	\$1,305			
Average Net Operating Revenue Per Case	\$540	\$540			
Average Net Operating Income Per Case Before Capital Expenditures	\$74	\$71			

C(II).6.A. PLEASE PROVIDE THE CURRENT AND PROPOSED CHARGE SCHEDULES FOR THE PROPOSAL. DISCUSS ANY ADJUSTMENT TO CURRENT CHARGES THAT WILL RESULT FROM THE IMPLEMENTATION OF THE PROPOSAL. ADDITIONALLY, DESCRIBE THE ANTICIPATED REVENUE FROM THE PROPOSED PROJECT AND THE IMPACT ON EXISTING PATIENT CHARGES.

The applicant will not have its gross charge structure modified by this project. Projected charges in 2017 reflect a 1% increase from current charges; 2018 reflects another 1% increase over 2017.

C(II).6.B. COMPARE THE PROPOSED CHARGES TO THOSE OF SIMILAR FACILITIES IN THE SERVICE AREA/ADJOINING SERVICE AREAS, OR TO PROPOSED CHARGES OF PROJECTS RECENTLY APPROVED BY THE HSDA. IF APPLICABLE, COMPARE THE PROJECTED CHARGES OF THE PROJECT TO THE CURRENT MEDICARE ALLOWABLE FEE SCHEDULE BY COMMON PROCEDURE TERMINOLOGY (CPT) CODE(S).

Table Ten below compares the applicant's <u>FYE 2014 and CY 2017</u> charges to the FYE 2014 charges of Nashville, Knoxville, and Maryville endoscopy centers.

Table Ten: Applicant's Charges in CY2017 Compared to FYE 2014 Charges at Dedicated Endoscopy Centers in Knoxville and Nashville						
at Dedicat	ed Endosc	copy Centers in F	Gross	nd Nashville	Net	
	Cases		Charges		Revenue	
Facility	(Patients)	Gross Charges	Per Case	Net Revenue	Per case	
Digest. Disease Endo.						
Center (Nashville)	6,162	\$9,148,179	\$1,485	\$5,242,063	\$851	
Nashville Endo. Center						
(Nashville)	2,870	\$11,209,263	\$3,906	\$2,128,551	\$742	
The Applicant						
FYE 2014	8,402	\$17,668,336	\$2,103	\$5,367,724	\$639	
The Applicant						
CY 2017	12,852	\$23,474,349	\$1,827	\$6,939,659	\$540	
The Endoscopy Center						
West (Knox)	4,193	\$8,937,499	\$2,132	\$2,501,911	\$597	
Associated Endoscopy						
(Nashville)	5,031	\$8,220,082	\$1,634	\$2,902,350	\$577	
The Endoscopy Center						
North (Knoxville)	5,353	\$11,650,650	\$2,176	\$3,018,963	\$564	
NV GI Endo. Center						
(Nashville)	2,594	\$2,748,480	\$1,060	\$1,210,816	\$467	
Mid-State Endo.						
Center (Nashville)	2,436	\$2,697,619	\$1,107	\$1,108,610	\$455	
Southern Endo. Center						
(Nashville)	2,711	\$2,707,995	\$999	\$1,153,111	\$425	
Tennessee Endoscopy						
Center (Maryville)	7,081	\$9,505,355	\$1,342	\$2,553,941	\$361	

Source: 2014 Joint Annual Reports of ASTC's and Projected Data Chart, this project.

The following page contains Table Eleven, showing the applicant's most frequent procedures performed, with their current Medicare reimbursement, and their projected Year One and Two average gross charges.

Tab	Table Eleven: Most Frequent Surgical Procedures and Average Gross Charges The Endoscopy Center (Knoxville)							
			Avera	Average Gross Charge				
СРТ	Descriptor	Current Medicare Allowable	Current Average	Year 1 CY2017	Year 2 CY2018			
43239	Upper gi endoscopy, biopsy	\$347.81	\$1,657	\$1,674	\$1,691			
45380	Colonoscopy and biopsy	\$368.45	\$1,657	\$1,674	\$1,691			
45385	Lesion removal colonoscopy	\$368.45	\$1,715	\$1,732	\$1,749			
G0105	Colorectal scrn; hi risk individual	\$305.56	\$1,657	\$1,674	\$1,691			
G0121	Colon ca scrn; not high risk	\$305.56	\$1,657	\$1,674	\$1,691			
45378	Diagnostic colonoscopy	\$368.45	\$1,657	\$1,674	\$1,691			
43248	Upper gi endoscopy/guide wire	\$347.81	\$1,657	\$1,674				
43235	Upper gi endoscopy, diagnosis	\$347.81	\$1,657	\$1,674	9			
43450	Dilate esophagus	\$347.81	\$1,246	\$1,258				
45381	Colonoscopy, submuccous inj	\$368.45	\$1,657	\$1,674	\$1,691			
45330	Flexible Sigmoidoscopy	\$85.22	\$652	\$659				
46221	Hemmorrhoidectomy	\$152.19	\$1,077	\$1,088				
45384	Lesion remove colonoscopy	\$368.45	\$1,715	\$1,732	\$1,749			
43259	Endoscopic ultrasound exam	\$496.73	\$1,847	\$1,865	\$1,884			
45331	Sigmoidoscopy and biopsy	\$230.29	\$1,246	\$1,258	\$1,271			

Source: AmSurg

# C(II).7. DISCUSS HOW PROJECTED UTILIZATION RATES WILL BE SUFFICIENT TO MAINTAIN COST-EFFECTIVENESS.

This is an existing endoscopy center that had a positive operating margin in 2014 and is operating currently with a positive margin. With a 2017 caseload larger than in 2014 and 2015, the facility is reasonably projected to maintain its cost-effectiveness while improving patient accessibility and improving facility efficiency.

# C(II).8. DISCUSS HOW FINANCIAL VIABILITY WILL BE ENSURED WITHIN TWO YEARS; AND DEMONSTRATE THE AVAILABILITY OF SUFFICIENT CASH FLOW UNTIL FINANCIAL VIABILITY IS MAINTAINED.

This existing endoscopy center is financially viable and has a positive cash flow. Its Projected Data Chart for 2017-2018 indicates that positive cash flow will continue at the new location.

C(II).9. DISCUSS THE PROJECT'S PARTICIPATION IN STATE AND FEDERAL REVENUE PROGRAMS, INCLUDING A DESCRIPTION OF THE EXTENT TO WHICH MEDICARE, TENNCARE/MEDICAID, AND MEDICALLY INDIGENT PATIENTS WILL BE SERVED BY THE PROJECT. IN ADDITION, REPORT THE ESTIMATED DOLLAR AMOUNT OF REVENUE AND PERCENTAGE OF TOTAL PROJECT REVENUE ANTICIPATED FROM EACH OF TENNCARE, MEDICARE, OR OTHER STATE AND FEDERAL SOURCES FOR THE PROPOSAL'S FIRST YEAR OF OPERATION.

Table Twelve-A below shows The Endoscopy Center's current overall payor mix. The Medicare and TennCare/Medicaid payor mix for Year One at the new location are shown in Table Twelve-B. The applicant projects maintaining approximately the same Medicare and TennCare/Medicaid payor mix that is currently being experienced.

Table Twelve-A: The Endoscopy Center (Knoxville) 2014-15 Payor Mix					
Payor Percentage					
Medicare	60.0%				
TennCare/Medicaid	1.0%				
Blue Cross	17.5%				
Other	21.5%				
Total	100.0%				

Table Twelve-B: The Endoscopy Center (Knoxville)						
Medicare and TennCare/Medicaid Revenues, Year One						
	Medicare	TennCare/Medicaid				
Gross Revenue	\$14,084,609	\$2,437,434				
Percent of Gross Revenue	60%	1%				

C(II).10. PROVIDE COPIES OF THE BALANCE SHEET AND INCOME STATEMENT FROM THE MOST RECENT REPORTING PERIOD OF THE INSTITUTION, AND THE MOST RECENT AUDITED FINANCIAL STATEMENTS WITH ACCOMPANYING NOTES, IF APPLICABLE. FOR NEW PROJECTS, PROVIDE FINANCIAL INFORMATION FOR THE CORPORATION, PARTNERSHIP, OR PRINCIPAL PARTIES INVOLVED WITH THE PROJECT. COPIES MUST BE INSERTED AT THE END OF THE APPLICATION, IN THE CORRECT ALPHANUMERIC ORDER AND LABELED AS ATTACHMENT C, ECONOMIC FEASIBILITY--10.

These are provided as Attachment C, Economic Feasibility--10.

C(II)11. DESCRIBE ALL ALTERNATIVES TO THIS PROJECT WHICH WERE CONSIDERED AND DISCUSS THE ADVANTAGES AND DISADVANTAGES OF EACH ALTERNATIVE, INCLUDING BUT NOT LIMITED TO:

A. A DISCUSSSION REGARDING THE AVAILABILITY OF LESS COSTLY, MORE EFFECTIVE, AND/OR MORE EFFICIENT ALTERNATIVE METHODS OF PROVIDING THE BENEFITS INTENDED BY THE PROPOSAL. IF DEVELOPMENT OF SUCH ALTERNATIVES IS NOT PRACTICABLE, THE APPLICANT SHOULD JUSTIFY WHY NOT, INCLUDING REASONS AS TO WHY THEY WERE REJECTED.

B. THE APPLICANT SHOULD DOCUMENT THAT CONSIDERATION HAS BEEN GIVEN TO ALTERNATIVES TO NEW CONSTRUCTION, E.G., MODERNIZATION OR SHARING ARRANGEMENTS. IT SHOULD BE DOCUMENTED THAT SUPERIOR ALTERNATIVES HAVE BEEN IMPLEMENTED TO THE MAXIMUM EXTENT PRACTICABLE.

The project site was chosen for its proximity to the current ASTC location, ease of interstate access, high visibility, and its location within a growing health care community of providers in the Dowell Springs area of Knox County.

The applicant cannot expand at its present location because no space is available for lease. At the proposed location, a third party will provide a newly constructed shell building; but the applicant's construction will all be build-out.

C(III).1. LIST ALL EXISTING HEALTH CARE PROVIDERS (I.E., HOSPITALS, NURSING HOMES, HOME CARE ORGANIZATIONS, ETC.) MANAGED CARE ORGANIZATIONS, ALLIANCES, AND/OR NETWORKS WITH WHICH THE APPLICANT CURRENTLY HAS OR PLANS TO HAVE CONTRACTUAL AND/OR WORKING RELATIONSHIPS, E.G., TRANSFER AGREEMENTS, CONTRACTUAL AGREEMENTS FOR HEALTH SERVICES.

The applicant has transfer agreements in place with Tennova Health System, whose replacement facility is being developed directly across Middlebrook Pike from the project site in Dowell Springs.

C(III).2. DESCRIBE THE POSITIVE AND/OR NEGATIVE EFFECTS OF THE PROPOSAL ON THE HEALTH CARE SYSTEM. PLEASE BE SURE TO DISCUSS ANY INSTANCES OF DUPLICATION OR COMPETITION ARISING FROM YOUR PROPOSAL, INCLUDING A DESCRIPTION OF THE EFFECT THE PROPOSAL WILL HAVE ON THE UTILIZATION RATES OF EXISTING PROVIDERS IN THE SERVICE AREA OF THE PROJECT.

## Benefits

The project will be beneficial to the health care system. A severely undersized endoscopy center will be enlarged and redesigned to be highly efficient and patient-friendly.

## Impact on Other Providers

1. AmSurg and GIA physicians own a network of three endoscopic ASTC's in Knox County: The Endoscopy Center on Weisgarber Road (the applicant in this project); the Endoscopy Center North; and the Endoscopy Center West. After the Weisgarber Road facility was forced to curtail its operating hours, many cases were moved to the North and West facilities. When the Weisgarber Road facility relocates to Dowell Springs, and resumes full-day operation, Dr. Matt Moore, who has been performing approximately 600 cases annually in the other two endoscopy centers, will transfer 600 cases to the main facility. This removal of cases from those facilities will still leave them with very high

utilization, as shown in Table Thirteen below--107% of the State Health Plan standard of 2,500 ambulatory surgery cases per procedure room.

2. Dr. Jeff Gilbert will transfer to this project approximately 2,200 endoscopy cases. He rerports that he currently performs those in nearby Oak Ridge at Covenant Health System's Methodist Medical Center and at the "Tennessee Endoscopy Center". The latter filed a JAR as a licensed ASTC for FYE2013. But it has been acquired by Covenant Health System and may be functioning now as a hospital-based outpatient department. The small impact of the project on Methodist Medical Center, based on the hospital's last reported (FY2013) total surgery cases, is shown in Table Thirteen below. Methodist Medical Center's FY 2014 surgical utilization is not known because its 2014 Joint Annual Report has not yet been released on the TDH website as of August 14, 2015. The volume in the table for Tennessee Endoscopy Center is from its CY2013 Joint Annual Report.

	Table Thirteen: Impact of Project on Other Providers								
	Reported	Most Recent	Cases		Cases Per				
Impacted	Surgical	Reported	Moving To	Percent	Room				
Facility	Rooms	Total Cases	This Project	Impact	Before/After				
Endoscopy									
Center North	2	6,237		12	440				
Endoscopy									
Center West	2	4,929		112	****				
Subtotal	4	11,266	600	-5.3%	2,817 / 2,667				
Methodist		(CY 2013)							
Medical Cntr.	13	6,965	440	-6.3%	536 / 502				
Tennessee		(FY2013)							
Endo. Center	3	4,838	1,760	-36.4%	1,613 / 1,026				

Sources: Applicant and TDH Joint Annual Reports.

It should be noted that it is a significant financial benefit to patients and insurors for endoscopy cases to be performed in an ASTC environment, rather than in a hospital outpatient department (HOPD). Medicare and most insurers pay 30%-40% less for these cases if done in an ASTC rather than a hospital. The movement of Dr. Gilbert's cases from a hospital to an ASTC will generate a significant cost savings for the public. The great majority of endoscopic surgeries in Tennessee have already migrated into ASTC's, for that and other reasons.

C(III).3. PROVIDE THE CURRENT AND/OR ANTICIPATED STAFFING PATTERN FOR ALL EMPLOYEES PROVIDING PATIENT CARE FOR THE PROJECT. THIS CAN BE REPORTED USING FTE'S FOR THESE POSITIONS. IN ADDITION, PLEASE COMPARE THE CLINICAL STAFF SALARIES IN THE PROPOSAL TO PREVAILING WAGE PATTERNS IN THE SERVICE AREA AS PUBLISHED BY THE TENNESSEE DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT AND/OR OTHER DOCUMENTED SOURCES.

The Department of Labor and Workforce Development website indicates the following Upper Central Tennessee region's annual salary information for clinical employees of this project:

Table Fourteen: TDOL Surveyed Average Salaries for the Region							
Position Entry Level Mean Median Experienced							
RN	\$46,246	\$57,282	\$56,767	\$62,800			
Medical Assistant	\$21,537	\$28,410	\$26,639	\$31,847			

Source: TDOLWD 2014 Survey, Knoxville Area

Table Fifteen on the following page provides current and proposed staffing patterns for the facility.

Table Fifteen: The Endoscopy Center (Knoxville)  Current and Projected Staffilng							
Position Type (RN, etc.)	Current FTE'S	Year One FTE's	Year Two FTE's	Annual Salary Range (\$)			
Center Administrator (RN)	0.3	0.3	1.0	66,000 - 87,000			
Charge RNs	1.4	1.4	4.4	56,000 - 72,000			
Staff RNs	9.4	11.1	8.3	41,600 - 62,400			
LPNs	2.2	2.5	2.6				
Endoscopy Techs	7.0	8.0	8.0	25,000 - 40,000			
Medical Assistants	2.6	2.7	2.7	25,000 - 40,000			
Receptionists	9.1	11.6	11.7	25,000 - 41,600			
Schedulers	2.0	2.0	2.0	25,000 - 35,000			
Billing	6.4	7.5	7.7	22,000 - 65,000			
Medical Records	2.0	2.3	2.4	25,000 - 36,000			
Total FTE's	42.2	49.5	50.7				

Source: AmSurg

C(III).4. DISCUSS THE AVAILABILITY OF AND ACCESSIBILITY TO HUMAN RESOURCES REQUIRED BY THE PROPOSAL, INCLUDING ADEQUATE PROFESSIONAL STAFF, AS PER THE DEPARTMENT OF HEALTH, THE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES, AND/OR THE DIVISION OF MENTAL RETARDATION SERVICES LICENSING REQUIREMENTS.

The applicant has excellent access to pools of clinical personnel in the East Tennessee market. AmSurg recruits both Statewide and nationally for its nurses and other clinical employees.

C(III).5. VERIFY THAT THE APPLICANT HAS REVIEWED AND UNDERSTANDS THE LICENSING CERTIFICATION AS REQUIRED BY THE STATE OF TENNESSEE FOR MEDICAL/CLINICAL STAFF. THESE INCLUDE, WITHOUT LIMITATION, REGULATIONS CONCERNING PHYSICIAN SUPERVISION, CREDENTIALING, ADMISSIONS PRIVILEGES, QUALITY ASSURANCE POLICIES AND PROGRAMS, UTILIZATION REVIEW PPOLICIES AND PROGRAMS, RECORD KEEPING, AND STAFF EDUCATION.

The applicant so verifies.

C(III).6. DISCUSS YOUR HEALTH CARE INSTITUTION'S PARTICIPATION IN THE TRAINING OF STUDENTS IN THE AREAS OF MEDICINE, NURSING, SOCIAL WORK, ETC. (I.E., INTERNSHIPS, RESIDENCIES, ETC.).

This small facility does not participate in the training of students.

C(III).7(a). PLEASE VERIFY, AS APPLICABLE, THAT THE APPLICANT HAS REVIEWED AND UNDERSTANDS THE LICENSURE REQUIREMENTS OF THE DEPARTMENT OF HEALTH, THE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES, THE DIVISION OF MENTAL RETARDATION SERVICES, AND/OR ANY APPLICABLE MEDICARE REQUIREMENTS.

The applicant so verifies.

C(III).7(b). PROVIDE THE NAME OF THE ENTITY FROM WHICH THE LICENSURE, RECEIVED OR WILL RECEIVE HAS APPLICANT CERTIFICATION, AND/OR ACCREDITATION

LICENSURE:

Board for Licensure of Healthcare Facilities

Tennessee Department of Health

**CERTIFICATION:** 

Medicare Certification from CMS

TennCare Certification from TDH

ACCREDITATION: Accreditation Association for Ambulatory Healthcare

(AAAHC)

IF AN EXISTING INSTITUTION, PLEASE DESCRIBE THE C(III).7(c). LICENSING, CERTIFYING, OR **STANDING** WITH ANY **CURRENT** ACCREDITING AGENCY OR AGENCY.

The applicant is currently licensed in good standing by the Board for Licensing Health Care Facilities, is certified for participation in Medicare and TennCare, and is fully accredited by the Accreditation Association for Ambulatory Healthcare (AAAHC).

C(III).7(d). FOR EXISTING LICENSED PROVIDERS, DOCUMENT THAT ALL DEFICIENCIES (IF ANY) CITED IN THE LAST LICENSURE CERTIFICATION AND INSPECTION HAVE BEEN ADDRESSED THROUGH AN APPROVED PLAN OF CORRECTION. PLEASE INCLUDE A COPY OF THE MOST RECENT LICENSURE/CERTIFICATION INSPECTION WITH AN APPROVED PLAN OF CORRECTION.

They have been addressed. A copy of the most recent licensure inspection and plan of correction, and/or the most recent accreditation inspection, are provided in Attachment C, Orderly Development--7(C).

C(III)8. DOCUMENT AND EXPLAIN ANY FINAL ORDERS OR JUDGMENTS ENTERED IN ANY STATE OR COUNTRY BY A LICENSING AGENCY OR COURT AGAINST PROFESSIONAL LICENSES HELD BY THE APPLICANT OR ANY ENTITIES OR PERSONS WITH MORE THAN A 5% OWNERSHIP INTEREST IN THE APPLICANT. SUCH INFORMATION IS TO BE PROVIDED FOR LICENSES REGARDLESS OF WHETHER SUCH LICENSE IS CURRENTLY HELD.

None.

C(III)9. IDENTIFY AND EXPLAIN ANY FINAL CIVIL OR CRIMINAL JUDGMENTS FOR FRAUD OR THEFT AGAINST ANY PERSON OR ENTITY WITH MORE THAN A 5% OWNERSHIP INTEREST IN THE PROJECT.

None.

C(III)10. IF THE PROPOSAL IS APPROVED, PLEASE DISCUSS WHETHER THE APPLICANT WILL PROVIDE THE THSDA AND/OR THE REVIEWING AGENCY INFORMATION CONCERNING THE NUMBER OF PATIENTS TREATED, THE NUMBER AND TYPE OF PROCEDURES PERFORMED, AND OTHER DATA AS REQUIRED.

Yes. The applicant will provide the requested data consistent with Federal HIPAA requirements.

## PROOF OF PUBLICATION

Attached.

## **DEVELOPMENT SCHEDULE**

1. PLEASE COMPLETE THE PROJECT COMPLETION FORECAST CHART ON THE NEXT PAGE. IF THE PROJECT WILL BE COMPLETED IN MULTIPLE PHASES, PLEASE IDENTIFY THE ANTICIPATED COMPLETION DATE FOR EACH PHASE.

The Project Completion Forecast Chart is provided after this page.

2. IF THE RESPONSE TO THE PRECEDING QUESTION INDICATES THAT THE APPLICANT DOES NOT ANTICIPATE COMPLETING THE PROJECT WITHIN THE PERIOD OF VALIDITY AS DEFINED IN THE PRECEDING PARAGRAPH, PLEASE STATE BELOW ANY REQUEST FOR AN EXTENDED SCHEDULE AND DOCUMENT THE "GOOD CAUSE" FOR SUCH AN EXTENSION.

Not applicable. The applicant anticipates completing the project within the period of validity.

### PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision Date, as published in Rule 68-11-1609(c):

November 18, 2015

Assuming the CON decision becomes the final Agency action on that date, indicate the number of days from the above agency decision date to each phase of the completion forecast.

PHASE	DAYS REQUIRED	Anticipated Date (MONTH /YEAR)	
1. Architectural & engineering contract signed	12	12-15	
2. Construction documents approved by TDH	102	2-16	
3. Construction contract signed	116	2-16	
4. Building permit secured	121	2-16	
5. Site preparation completed	na	na	
6. Building construction commenced	131	3-16	
7. Construction 40% complete	221	6-16	
8. Construction 80% complete	311	9-16	
9. Construction 100% complete	401	11-16	
10. * Issuance of license	415	12-16	
11. *Initiation of service	417	1-17	
12. Final architectural certification of payment	477	3-17	
13. Final Project Report Form (HF0055)	537	5-17	

<sup>\*</sup> For projects that do NOT involve construction or renovation: please complete items 10-11 only.

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

### **INDEX OF ATTACHMENTS**

A.4 Ownership Documentation and Information A.5 Management Contract A.6 Site Control B.II.A. Square Footage and Costs Per Square Footage Chart B.III. Plot Plan B.IV. Floor Plan C. Need—1.A Documentation of Project-Specific Criteria 1. Anesthesia commitment 2. Medically Underserved Areas of PSA C, Need--1.A.3. Letters of Intent & Qualifications 1. Case Commitments--New Physicians 2. Medical staff Board Certifications C, Need--3 Service Area Maps 1. Locations of Project Sites in Knoxville 2. Primary service area in Tennessee 3. Bus Route Access to Site C, Economic Feasibility--1 Documentation of Construction Cost Estimate 1. Architect's Attestation C, Economic Feasibility--2 Documentation of Availability of Funding 1. Chief Financial Officer's Letter and Amortization Schedule C, Economic Feasibility--10 **Financial Statements** 1. Applicant 2. AmSurg C, Orderly Development--7(C) 1. TDH Acceptance of Plan of Correction 2. Licensing & Accreditation Inspections Miscellaneous Information 1. Approved Procedures for This Facility 2. Transfer Agreements 3. TennCare Enrollments, TN PSA 4. Quickfacts County Data 5. Amendments to Applicant's 2013 JAR

Support Letters

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Support Letters

### A.4--Ownership Legal Entity and Organization Chart

# Woard for Aicensing Health Care Facilities



License No.

## DEPARTMENT OF HEALTH

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THE ENDOSCOPY CENTER OF KNOXVILLE, L.P.

to conduct and maintain

rn Ambulatory Surg	an Ambulatory Ingical Treatment Center THE ENDOSCOPY CENTER	ENDOSCOPY CENTER
Docated at 80	801 WEISGARBER ROAD, STE 100, KNOXVILLE	IOXVILLE
County of KA	KNOX	Tennessee.
This licen	This license shall expire.	MAY 05 , and is subje
to the provisions of Enapter 11,		Tennessee Code Annotated. This license shall not be assignable or transferable
and shall be subject to	revocation at any time by	and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the
laws of the State of	Tennessee or the rules and	laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunde
In Witness Moved,	we have hereunto set our ha	In Witness Mereof, we have hereunto set our hand and seal of the State this 5TH day of MAY
In the Speciality (ies) of: GASTROENTEROLOGY	of GASTROENTEROLOGY	



DIRECTOR, DIVISION OF HEATH CARE FACILITIES

Ru



October 15, 2012

Organization #:

13979

Organization:

The Endoscopy Center, LLC

Address:

801 North Weisgarber Road, Suite 100

City, State, Zip:

Knoxville, TN 37909-2707

Decision Recipient:

Gayle Mahan, RN

**Survey Date:** 

October 1-2, 2012

Type of Survey: Re-accreditation

Survey Chairperson:

Archer Rose, FACHE

Survey Team Members:

Laurence Hausman, MD Garry Feld, BA, MS, FACHE

Accreditation Term Begins: October 11, 2012

Accreditation Term Expires: October 10, 2015

Accreditation Renewal Code:

efad980b13979

Complimentary study participation code: 13979FREEIQI

Satellites: See page 2

Granting accreditation reflects confidence, based on evidence from this recent survey that you meet, and will continue to demonstrate throughout the accreditation term, the attributes of an accreditable organization, as reflected in the standards found in the Accreditation Handbook for Ambulatory Health Care. The dedication and effort necessary for an organization to be accredited is substantial and the compliance with those standards implies a commitment to continual self-evaluation and continuous improvement. If your organization was required to submit a plan for improvement, receipt of this letter denotes acceptance of the plan for improvement.

We hope the survey has been beneficial to your organization in identifying its strengths and opportunities to improve. AAAHC trusts that you will continue to find the accreditation experience meaningful, not only from the benefit of having carefully reviewed your own operation, but also from the recognition brought by your participation in this survey process.

Members of your organization should take time to review your Survey Report, which may arrive separately:

- Any standard marked "PC" (Partially Compliant) or "NC" (Non-Compliant) must be corrected promptly. Subsequent surveys by the AAAHC will seek evidence that deficiencies from this survey were addressed without
- The Summary Table provides an overview of compliance for each chapter applicable to the organization.
- Statements in the "Consultative Comments" sections of the report represent the educational component of the survey. Such comments may provide helpful guidance for improvement,
- As a guide to the ongoing process of self-evaluation, periodic review of the Survey Report and the current year's Handbook will ensure the organization's ongoing compliance with the standards throughout the term of accreditation.

AAAHC policies and procedures and standards are revised on an annual basis, such revisions become effective March 1 each year. Accredited organizations are required to maintain their operations in compliance with the current AAAHC standards and policies. Therefore, the organization is encouraged to visit the AAAHC website, www.aaahc.org, for information pertaining to any revisions to AAAHC policies and procedures and standards.

In order to ensure continuation of accreditation, your organization should submit an application for survey approximately five months prior to your accreditation expiration. According to our Accreditation Handbook,

Currently-accredited organizations must complete and submit the Application for Survey, supporting documentation, and application fee for their subsequent full accreditation survey (referred to as a re-accreditation survey). Please visit www.aaahc.org to complete the Application for Survey and for further information. After review of an organization's completed Application for Survey and supporting documentation, the AAAHC will contact the organization to establish survey dates. To prevent a lapse in accreditation, an organization should ensure that all documentation is submitted to the AAAHC at least five (5) months prior to its accreditation expiration date. In states

Organization #:

13979

Accreditation Expires:

October 10, 2015

Organization:

The Endoscopy Center, LLC

October 15, 2012 Page 2

where accreditation is mandated by law, an organization should submit the completed Application for Survey and other required documentation a minimum of six (6) months prior to its accreditation expiration date.

For submission of an application for survey, your organization will need the "accreditation renewal code" located underneath the accreditation expiration date.

You will notice that you have a "complimentary study participation code" at the top of this letter. You may use this to register for one of the AAAHC Institute for Quality Improvement's studies. Please visit <a href="www.aaahc.org/institute">www.aaahc.org/institute</a> for additional information or contact Michelle Chappell, at 847-324-7747 or <a href="machappell@aaahc.org">mchappell@aaahc.org</a>.

If you have any questions or comments about any portion of the accreditation process, please contact the AAAHC Accreditation Services department at (847) 853-6060.

### Satellites:

The Endoscopy Center, LLC - North 629 Delozier Way Powell, TN 37849

The Endoscopy Center, LLC - West 11440 Parkside Drive, Suite 100 Knoxville, TN 37934

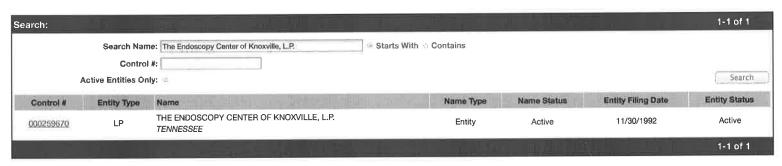


Business Services Online > Find and Update a Business Record

### **Business Information Search**

As of June 18, 2015 we have processed all corporate filings received in our office through June 17, 2015 and all annual reports received in our office through June 17, 2015.

Click on the underlined control number of the entity in the search results list to proceed to the detail page. From the detail page you can verify the entity displayed is correct (review addresses and business details) and select from the available entity actions - file an annual report, obtain a certificate of existence, file an amendment, etc.



Information about individual business entities can be queried, viewed and printed using this search tool for free.

If you want to get an electronic file of all business entities in the database, the full database can be downloaded for a fee by Clicking Here.

Click Here for information on the Business Services Online Search logic.

Division of Business Servic 312 Rosa L. Parks Avenue, Snodgrass Floor Nashville, TN 37243 615-741-2286 Email Directions Hours and Holidays Method	Tower, 6th  Certified (  Mo  Uni  S of Payment  Workers* Co	ss Filings and Information (615) 741-2286   TNS Copies and Certificate of Existence (615) 741-6 stor Vehicle Temporary Liens (615) 741-0529   T form Commercial Code (UCC) (615) 741-3276   impensation Exemption Registrations (615) 741- Apostilles & Authentications (615) 741-0536   TI Summons (615) 741-1799   TNSOS.A	188   TNSOS.CERT@tn.gov NSOS.MVTL@tn.gov TNSOS.UCC@tn.gov -0526   TNSOS.WCER@tn.gov NSOS.ATS@tn.gov TS@tn.gov
OUR MISSION  Our mission is to exceed the dispetitations of our customers, the hispayers, by operating at the highest	CUSTOMER SUPPORT  Contact Us  TSLA Visitor Information	DIVISIONS  Administrative Hearings  Business Services	LINKS  Tennessee General Assembly  Bureau of Ethics and Campaign Finance
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	INFORMATION  About the Secretary of State's Office	Human Resources and Organizational Development	State Comptroller State Treasurer



Business Services Online > Find and Update a Business Record

### **Business Information Search**

As of July 04, 2015 we have processed all corporate filings received in our office through July 02, 2015 and all annual reports received in our office through July 02, 2015.

Click on the underlined control number of the entity in the search results list to proceed to the detail page. From the detail page you can verify the entity displayed is correct (review addresses and business details) and select from the available entity actions - file an annual report, obtain a certificate of existence, file an amendment, etc.

ch:					1 2	1-1 of 1
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Activ	e Entities Only:					Search
Control #	Entity Type	Name	Name Type	Name Status	Entity Filing Date	Entity Status
000257715	CORP	AMSURG KEC, INC. TENNESSEE	Entity	Active	09/29/1992	Active
						1-1 of 1

Information about individual business entities can be queried, viewed and printed using this search tool for free.

If you want to get an electronic file of all business entities in the database, the full database can be downloaded for a fee by Clicking Here.

Glick Here for information on the Business Services Online Search logic.

Division of Business Services Business Filings and Information (615) 741-2286 | TNSOS.CORPINFO@tn.gov 312 Rosa L. Parks Avenue, Snodgrass Tower, 6th Certified Copies and Certificate of Existence (615) 741-6488 | TNSOS.CERT@tn.gov Motor Vehicle Temporary Liens (615) 741-0529 | TNSOS.MVTL@tn.gov Nashville, TN 37243 615-741-2286 Uniform Commercial Code (UCC) (615) 741-3276 | TNSOS UCC@tn.gov Email Directions Hours and Holidays Methods of Payment Workers' Compensation Exemption Registrations (615) 741-0526 | TNSOS.WCER@tn.gov Apostilles & Authentications (615) 741-0536 | TNSOS.ATS@tn.gov Summons (615) 741-1799 | TNSOS ATS@tn.gov Trademarks (615) 741-0531 | TNSOS ATS@tn.gov LINKS DIVISIONS CUSTOMER SUPPORT OUR MISSION Tennessee General Assembly Administrative Hearings Contact Us customers, the taxpayers, by operating at the highest levels of accuracy, cost-effectiveness, and accountability in a customer-centered environment. Bureau of Ethics and Campaign Finance **Business Services** TSLA Visitor Information Tennessee Code Unannotated Charitable Solicitations and Gaming NASS DEPARTMENT Elections INFORMATION State Comptroller Human Resources and Organizational Development State Treasurer About the Secretary of State's Office

### AGREEMENT OF LIMITED PARTNERSHIP OF THE ENDOSCOPY CENTER OF KNOXVILLE, L.P.

This Agreement of Limited Partnership is made and entered into effective as of November 30, 1992, between AmSurg KEC, Inc., a Tennessee corporation, as general partner (the "General Partner"), and The Endoscopy Center, a Tennessee general partnership, as limited partner (the "Limited Partner").

The parties hereto agree as follows:

### 1. DEFINITIONS

When used in this Agreement, the following terms shall have the meanings set forth below:

- 1.1. "Act" means the Revised Uniform Limited Partnership Act, as adopted in the State of Tennessee, as the same may be amended from time to time.
- 1.2. "Affiliate" means any person or corporation directly or indirectly controlling, controlled by or under common control with the General Partner.
- 1.3. "Agreement" means this Agreement of Limited Partnership, as amended from time to time.
- 1.4. "Available Cash Flow" means all cash funds of the Partnership on hand at the end of each month, less (i) provision for payment of all outstanding and unpaid current cash obligations of the Partnership at the end of such month (including those which are in dispute) and (ii) provisions for adequate reserves for reasonably anticipated cash expenses and contingencies (which may include debt service on Partnership indebtedness and fees payable to the General Partner and its affiliates) as determined by the General Partner in its sole discretion, but without deduction for depreciation and other noncash expenses; provided, however, that Sale Proceeds shall not be included in Available Cash Flow.
- 1.5. "Capital Contribution" in respect of any Partner or transferee of such Partner means the amount of all cash and other property, tangible or intangible, contributed by such Partner to the capital of the Partnership.
- 1.6. "Center" means the ambulatory surgical center operated by the Partnership, including the real property or leasehold improvements, furniture, fixtures, the Equipment, books, records, supplies and other assets used in its operation.
- 1.7. "Code" means the Internal Revenue Code of 1986, as amended, and the regulations adopted thereunder.

- 1.8. "Equipment" means the equipment used in connection with the operation of the Center.
- 1.9. "Fundamental Regulatory Change" means any change in federal or state law that results in (i) the referral of Medicare or any other patients to the Center by the Limited Partner, or the submission of claims to Medicare for services performed by or at the direction of the Limited Partner, becoming illegal, (ii) the existence of a substantial likelihood that the receipt of cash distributions from the Partnership by the Limited Partner is or will be found to be in violation of federal or state law, or (iii) the ownership by the Limited Partner of an interest in the Partnership becoming illegal.
  - 1.10. "Fiscal Year" shall mean the fiscal year of the General Partner.
- 1.11. "General Partner" means AmSurg KEC, Inc., a Tennessee corporation, and any substitute therefor elected as provided in Section 12.4 of this Agreement.
- 1.12. "Limited Partners" means the persons who are, from time to time, admitted to the Partnership as Limited Partners, and whose names, addresses and taxpayer identification numbers, and the partnership interest owned by each, appear as Annex A to this Agreement, as amended from time to time. Such persons shall become Limited Partners when a duly executed amendment to Annex A to this Agreement showing that such persons have become Limited Partners is executed by the General Partner.
  - 1.13. "Partners" means collectively the General Partner and the Limited Partners.
  - 1.14. "Partnership" means the limited partnership formed pursuant to this Agreement.
- 1.15. "Partnership Return" means the U.S. Partnership Information Return of Income of the Partnership.
- 1.16. "Partnership Profit" means net income of the Partnership for the applicable period determined on an accrual basis in accordance with generally accepted accounting principles. Whenever reference is made to a calculation that requires use of the Partnership's profit for the preceding 12 months, and the Partnership has not been in operation for 12 months, such reference shall be deemed to be a reference to the Center's net income for the preceding 12 months determined on an accrual basis in accordance with generally accepted accounting principles.
- 1.17. "Sale Proceeds" means all proceeds of any sale, exchange, foreclosure, abandonment, financing or refinancing of capital assets of the Partnership, or from condemnation awards or casualty insurance claims less applicable expenses and any debt paid or prepaid with the proceeds of or in connection with such transaction, which proceeds are not used to acquire Partnership assets.

### 2. ORGANIZATION

- 2.1. <u>Formation</u>. The parties hereby form a Limited Partnership under and pursuant to the Act. As required by the Act, the General Partner shall file with the Secretary of State of the State of Tennessee, and in such other places as may be required by law, any certificates or other documents necessary to protect the status of the Partnership as a limited partnership and as otherwise required by law.
- 2.2. Name. The name of the Partnership is The Endoscopy Center of Knoxville, L.P. The business of the Partnership may be conducted under any name chosen by the General Partner.

### 3. PRINCIPAL PLACE OF BUSINESS AND REGISTERED OFFICE

3.1. <u>Principal Place of Business</u>. The principal place of business of the Partnership shall be at 2301 21st Avenue South, Suite 300, Nashville, Tennessee 37212 or at such other place as the General Partner may from time to time designate by notice to the Limited Partners.

### 4. BUSINESS

The business to be conducted by the Partnership shall be to own and operate the Center and to carry on any and all activities necessary, proper, convenient, or advisable in connection therewith.

### 5. TERM

The Partnership shall exist until December 31, 2042, unless terminated sooner pursuant to Article 13 of this Agreement.

### 6. CAPITAL CONTRIBUTION, STATUS AND ADDITIONAL WORKING CAPITAL

- 6.1. <u>Capital Contribution of the Partners</u>. The General Partner is contributing its 51% undivided interest in the assets comprising the business of the Center and the Limited Partner is contributing its 49% undivided interest in the same assets. Notwithstanding the foregoing, the General Partner shall not contribute the non-competition agreement of the Limited Partner contained in Section 5.4. of the Asset Purchase Agreement dated October 30, 1992 by and between the General Partner and the Limited Partner.
- 6.2. Capital Accounts. Each Partner shall have a capital account to which the fair market value of such Partner's capital contribution shall be credited (the "Capital Account"). Each Partner's share of the income, including tax-exempt income, expenses, gain or loss of the Partnership shall be charged or credited at least monthly to such Partner's Capital Account. All distributions to a Partner shall be charged to such Partner's Capital Account. No interest shall be payable on the Capital Accounts of the Partners. The Capital Accounts shall be maintained and adjusted in accordance with the principles set forth in Treasury Regulation Section 1.704-1(b)(2)(iv), and the items of income, profit, gain, expenditures, deductions and losses which increase or decrease such Capital Accounts shall be those items which, pursuant to such provision, affect the balance of capital accounts.
- 6.3. Mandatory Capital Contributions by General Partner. The Capital Account of the General Partner for each Fiscal Year shall be equal to at least one and one-hundredths percent (1.01%) of the total capital account balances of all Limited Partners. The General Partner hereby agrees to make such capital contributions as may be required from time to time to satisfy this requirement.
- 6.4. <u>Limited Liability</u>. A Limited Partner, as such, shall not be bound by, or personally liable for, the expenses, liabilities or obligations of the Partnership in excess of such Limited Partner's Capital Contribution; except (a) in the event that the Partnership makes a distribution to the Limited Partners, and after giving effect to such distribution, all liabilities of the Partnership would exceed the fair value of the Partnership's assets, a Limited Partner may be required to return to the Partnership all or a portion of such distribution, or (b) as otherwise required by the Act.
- 6.5. Role of Limited Partners. Except as otherwise provided in this Agreement, a Limited Partner, as such, shall take no part in or interfere in any manner with the conduct or control of the business of the Partnership and shall have no right or authority to act for or bind the Partnership.
- 6.6. <u>Assessments</u>. The Limited Partner will not be subject to additional assessments for contributions to the capital of the Partnership.

as it deems necessary, lend, or arrange for the Partnership to borrow, additional working capital sufficient to enable the Partnership to carry on its business as contemplated by Article 4 hereof. Any loan by the General Partner to the Partnership shall be evidenced by a promissory note which shall bear interest at a rate equal to the "prime rate" of interest as reported for Third National Bank in Nashville, Tennessee and which shall contain other terms substantially similar to those which might be agreed to with a non-affiliated lender.

### 7. EXPENSES OF THE PARTNERSHIP

- 7.1. Reimbursement of Expenses Incurred by the General Partner. The General Partner may charge the Partnership for all reasonable and necessary direct expenses incurred by it in connection with the Partnership's business, including legal, accounting, record keeping, tax return preparation and data processing services.
- 7.2. Organizational Expenses. All expenses incurred in connection with the formation of the Partnership shall be paid by the Partnership, not to exceed \$10,000.
- 7.3. Fees Receivable By the General Partner and Affiliates of the General Partner. An Affiliate of the General Partner will receive from the Partnership certain fees, pursuant to the terms of a Management Services Agreement pursuant to which an Affiliate of the General Partner will be paid a management fee equal to 2.5% of the Partnership's net revenues. The Limited Partner, by its execution of this Agreement, hereby approves, ratifies and consents to the arrangements contemplated by the foregoing Management Agreement.

### 8. ALLOCATION OF INCOME AND LOSS

- 8.1. Allocation of Net Taxable Income or Loss and Tax Credits. All income and gain of the Partnership includable for federal income tax purposes, all expenses and losses of the Partnership deductible for federal income tax purposes (excluding any gain or loss from the Partnership's disposition of all or substantially all of its assets), and all federal income tax credits shall be allocated in proportion to each Partner's respective Capital Accounts unless otherwise required by applicable provisions of the Code.
- 8.2. Allocations to Reflect Contributed Property. If a Partner contributes property to the Partnership which has a difference between its tax basis and its fair market value on the date of its contribution (including the assets comprising a 49% undivided interest in the Center contributed by the Limited Partner), then all items of income, gain, loss and deduction with respect to such contributed property shall be shared for federal income tax purposes among the Partners pursuant to Section 704(c) of the Code so as to take into account the variation between the basis of such property and its fair market value at the time of contribution. To the extent permitted by Treasury Regulations, the General Partner may elect to aggregate contributed properties for purposes of the allocations under this Section 8.2, provided that all the properties

so aggregated must have a tax basis less than, or all such properties must have a tax basis greater than, their respective fair market value at the time of contribution.

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Without limiting the generality of the foregoing, the depreciation and amortization deductions allowable under federal tax rules on the assets comprising the business of the Center contributed by the General Partner and the Limited Partner shall be allocated for federal income tax purposes first to the General Partner to the extent of the General Partner's share of the book depreciation or amortization on such assets, such share being based on the percentage undivided interest of the General Partner in the assets at the time of their contribution; and any remaining depreciation or amortization shall be allocated to the Limited Partner.

- 8.3. <u>Distribution of Available Cash Flow</u>. The General Partner shall distribute the Available Cash Flow. Such distributions shall be made in monthly installments within 15 days after the end of each month and shall be made in proportion to the Capital Account balances of the General Partner and the Limited Partner at the time of each distribution.
- 8.4. <u>Distribution of Sale Proceeds</u>. The General Partner shall distribute Sale Proceeds in proportion to the Partners' respective Capital Accounts unless otherwise required by applicable provisions of the Code. Such distribution shall be made as soon after the receipt by the Partnership of such Sale Proceeds as the General Partner deems practicable. Notwithstanding anything to the contrary above, in the event that the Partnership sells its assets for a combination of cash and notes, the Limited Partner and the General Partner shall each be entitled to (i) their proportionate share of the remaining cash and (ii) an undivided interest in each note received by the Partnership and shall be paid their proportionate share of principal and interest on such notes as the purchaser pays such amounts.
- 8.5. Consequences of Distributions. Upon the determination to distribute funds in any manner expressly provided in this Article 8, made in good faith, the General Partner shall incur no liability on account of such distribution, even though such distribution may have resulted in the Partnership retaining insufficient funds for the operation of its business which insufficiency resulted in loss to the Partnership or necessitated the borrowing of funds by the Partnership.
- 8.6. <u>Distributions upon Termination</u>. When the Partnership is terminated, pursuant to Section 13 or otherwise, the final distribution to Partners shall be according to the balance of their Capital Accounts, after allocation of income, gain, expense and loss in the Fiscal Year of termination (including the allocation for the deemed sale of assets distributed in kind required by Section 13.2).

### 9. RIGHTS, POWERS AND OBLIGATIONS OF THE GENERAL PARTNER

9.1. <u>Powers</u>. The management and control of the Partnership and its business and affairs shall rest exclusively with the General Partner, which shall have all the rights and powers which may be possessed by a general partner pursuant to the Act, and such additional rights and powers as are otherwise conferred by law or are necessary, advisable or convenient to the

discharge of its duties under this Agreement. The General Partner shall be the "tax matters partner" within the meaning of the Code. Subject to the provisions of this Article 9 and without limiting the generality of the foregoing, the General Partner may, on behalf of and at the cost, expense and risk of the Partnership:

- 9.1.1. Spend the capital and net income of the Partnership in the exercise of any rights or powers possessed by the General Partner hereunder;
- 9.1.2. Lease, acquire, own, manage and operate the Center, and enter into agreements containing such terms, provisions and conditions as the General Partner in its discretion shall approve;
- 9.1.3. Purchase from or through others contracts of liability, casualty and other insurance which the General Partner deems advisable for the protection of the Partnership or for any purpose convenient or beneficial to the Partnership;
- 9.1.4. Incur indebtedness in the ordinary course of business and indebtedness incurred or assumed in connection with the acquisition of, construction of, or improvement to the Center or any refinancing thereof;
- 9.1.5. Subject to the provisions of Section 9.4.2.1 of this Agreement, sell or otherwise dispose of, upon such terms and conditions as the General Partner may deem advisable, appropriate or convenient, any of the assets of the Partnership;
- 9.1.6. Invest in short-term debt obligations (including obligations of federal and state governments and their agencies, commercial paper and certificates of deposit of commercial banks, savings banks or savings and loan associations) and "money market" mutual funds, such funds as are temporarily not required for the purposes of the Partnership's operations; and
- 9.1.7. Delegate all or any of its duties hereunder and, in furtherance of any such delegation, appoint, employ, or contract with any person (including Affiliates) for the transaction of the business of the Partnership, which persons may, under the supervision of the General Partner, act as consultants, accountants, attorneys, brokers, escrow agents, or in any other capacity deemed by the General Partner necessary or desirable, and pay appropriate fees to any of such persons.
- 9.2. <u>Duties</u>. The General Partner shall manage and control the Partnership, its business and affairs to the best of its ability and shall use its best efforts to carry out the business of the Partnership in the best interests of all Partners. The General Partner shall devote itself to the business of the Partnership to the extent that it, in its discretion, deems necessary for the efficient carrying on thereof. The General Partner shall act as a fiduciary with respect to the safekeeping and use of the funds and assets of the Partnership.

9.3. Advisory Board. The Partnership shall have an Advisory Board consisting of four persons, two of whom are appointed by the General Partner and two of whom are appointed by the Limited Partner. The Advisory Board will advise the General Partner with respect to certain aspects of the Partnership's operations.

### 9.4. Certain Limitations.

- 9.4.1. Except as otherwise provided herein, the General Partner shall not do any act which the general partner of a limited partnership is prohibited from doing under Tennessee Law.
- 9.4.2. Without obtaining the consent of the Advisory Board, the General Partner shall not:
  - 9.4.2.1. Sell or transfer all or substantially all of the assets of the Partnership; provided, however, that the General Partner may grant a security interest in such assets;
    - 9.4.2.2. Dissolve the Partnership;
    - 9.4.2.3. Merge or consolidate the Partnership into another entity;
  - 9.4.2.4. Incur any long-term indebtedness on behalf of the Partnership in excess of \$50,000;
    - 9.4.2.5. Establish operating and capital budgets for the Center;
  - 9.4.2.6. Enter into an agreement to make any single capital expenditure in excess of \$25,000 or aggregate annual capital expenditures of in excess of \$50,000;
  - 9.4.2.7. Change in any material respect the operating policies and procedures of the Center; or
    - 9.4.2.8. Change the name of the Partnership.
- 9.4.3. The Limited Partner shall have a right of first refusal with respect to any sale of all or substantially all of the Partnership's assets or any sale of the General Partner's interest in the Partnership. This right shall expire 30 days after the Limited Partner receives written notification of the proposed sale, setting forth the consideration to be paid. This provision shall not apply to any transaction which includes the sale of all or substantially all of the assets of AmSurg Corp.

- 9.5. Net Worth of the General Partner. The General Partner shall have and maintain at all times during which it is the General Partner of the Partnership a net worth which is sufficient to conduct the business of the Partnership in a prudent manner and necessary to avoid the taxation of the Partnership as an association taxable as a corporation.
- 9.6. Right to Rely Upon the Authority of the General Partner. No person dealing with the General Partner shall be required to determine its authority to make any commitment or undertaking on behalf of the Partnership, nor to determine any fact or circumstance bearing upon the existence of its authority. In addition, no purchaser of any property of the Partnership shall be required to determine the sole and exclusive authority of the General Partner to sign and deliver on behalf of the Partnership any instrument of transfer, or to see to the application or distribution of revenues or proceeds paid or credited in connection therewith, unless such purchasers shall have received written notice from the Partnership affecting the same.

### 10. LIMITED PARTNERS

10.1. Non-Competition. The Limited Partner shall not be a consultant to, or have any direct or indirect ownership interest in, or manage, lease, develop or otherwise have any financial interest in, or receive compensation from any business or entity competing with the Partnership within 50 miles of the Center until the later of (i) five years from the date of this Agreement, or (ii) one year after the Limited Partner ceases to be a Partner.

No partner of the Limited Partner shall have any direct or indirect ownership interest in, or manage, lease, develop or otherwise have a financial interest in, any business or entity competing with the Partnership within 50 miles of the Center until the later of (i) five years from the date of this Agreement, or (ii) one year after such partner ceases to be a partner of the Limited Partner. The foregoing shall not prohibit any partner of the Limited Partner from (i) owning shares of the common stock of any corporation whose common stock is traded on a national securities exchange, or (ii) providing professional and/or consulting services to providers of healthcare services, provided such partner is compensated, directly or indirectly, only through the payment of professional fees arising out of medical services provided by such partner to patients. Prior to admitting a new partner to its partnership, the Limited Partner shall require such new partner to agree in writing to the provisions of this Section 10.1.

- 10.2. <u>Medical Malpractice Insurance</u>. The Limited Partner will ensure that each practicing physician with staff privileges at the Center who is a partner or employee of the Limited Partner shall maintain at all times medical malpractice insurance complying with the Medical Bylaws of the Center.
- 10.3. <u>Independent Medical Judgment</u>. No provision of this Agreement shall limit the independent medical judgment of each practicing physician with staff privileges at the Center with regard to the providing of patient care. Further, nothing contained herein requires any

practicing physician with staff privileges at the Center to use or recommend the use of facilities or services owned, operated or provided by the Partnership.

### 11. TRANSFER OF INTERESTS IN THE PARTNERSHIP

- 11.1. <u>In General</u>. The Limited Partner may not sell, assign or otherwise transfer any or all of the partnership interests owned by it unless it complies with the following conditions:
  - 11.1.1. The General Partner must consent to the sale, assignment or transfer of any interest in the Partnership. The General Partner will not consent to any sale, assignment, or transfer of any interest in the Partnership or to the admission of any person as a substituted Limited Partner if, in its opinion, such consent and/or substitution would result in the Partnership being treated for federal income tax purposes as an association taxable as a corporation, would result in a termination of the Partnership within the meaning of the Code or would constitute a violation of any applicable federal or state law.
  - 11.1.2. The sale, assignment, or transfer must be made to (a) an individual person who is approved by the Advisory Board of the Center, (b) a corporation, partnership, professional corporation, trust, pension or profit sharing plan or other entity or person affiliated or associated with such an individual, and determined by the General Partner, in its sole judgment, to be a suitable transferee of such interest in the Partnership, or (c) the General Partner or an Affiliate.
  - 11.1.3. The transferring Limited Partner and purchaser, assignee or transferee must execute and deliver to the General Partner such instruments of transfer and assignment with respect to such transaction as are in form and substance satisfactory to the General Partner and its counsel.
  - 11.1.4. The transferring Limited Partner must pay the Partnership a transfer fee which is sufficient to pay all reasonable expenses of the Partnership in connection with such transaction.
- 11.2. <u>Substituted Partners</u>. A purchaser, assignee, or transferee of an interest in the Partnership shall become a substituted Limited Partner within the meaning of the Act if:
  - 11.2.1. The General Partner consents in writing to such person becoming a substituted Limited Partner;
  - 11.2.2. Such person elects to become a substituted Limited Partner by delivering a written notice of such election to the General Partner;

- 11.2.3. Such person executes and acknowledges such other instruments as the General Partner may deem necessary or advisable to effect the admission of such person as a substituted Limited Partner, including, without limitation, the written acceptance and adoption by such person of the provisions of this Agreement; and
- 11.2.4. A transfer fee is paid to the Partnership which is sufficient to cover all reasonable expenses connected with the admission of such person as a substituted Limited Partner within the meaning of the Act.

The General Partner shall then amend Annex A of this Agreement and shall take all other steps which, in the opinion of the General Partner, are reasonably necessary to admit such person as a substituted Limited Partner under the Act.

- 11.3. Required Transfer of Limited Partner's Interest. In the event the Limited Partner is granted relief under Title 11, United States Code, or makes a general assignment for the benefit of creditors or takes the benefit of any insolvency act, or if a permanent receiver or trustee in bankruptcy is appointed for the Limited Partner's property, or if a temporary receiver be appointed for the Limited Partner and such appointment is not vacated or set aside within sixty (60) days from the date of such appointment, the Limited Partner shall promptly provide the General Partner notice of such event, and the General Partner may, at its sole election, require the Limited Partner to sell its interest in the Partnership to the Partnership at a price equal to three (3) times the Limited Partner's share of the Partnership's Profit for the preceding twelve month period. The Partnership shall have ninety (90) days from the date the General Partner has notice of a qualifying event above described to purchase the interest of the Limited Partner pursuant to the provisions hereof.
- 11.4. Government Regulation. Subject to the right of the General Partner to amend this Agreement pursuant to Section 17.3, if a Fundamental Regulatory Change should occur, the General Partner or its Affiliates or assigns shall purchase some or all of the Partnership interest of the Limited Partner for a purchase price equal to (i) if the foregoing purchase results in the General Partner owning no more than 60% of the Partnership interests, four (4) times the Limited Partner's share of the Partnership's Profit for the preceding twelve months represented by the Partnership interest purchased, and (ii) if the foregoing purchase results in the General Partner owning in excess of 60% of the Partnership interests, the sum of (x) four (4) times the Limited partner's share of the Partnership Profit for the preceding twelve months for that portion of Partnership interests purchased that results in the General Partner owning 60% of the Partnership interests and (y) three (3) times the Limited Partner's share of the Partnership Profit for the preceding twelve months represented by the balance of the Partnership interests purchased. The purchase price shall be paid as follows: 20% shall be paid in cash, 30% shall be paid in the form of promissory notes as provided in Section 11.5, with the balance to be paid, at the option of the General Partner, in cash or in shares of the common stock of AmSurg Corp. as provided in Section 11.6. The determination that a Fundamental Regulatory Change has occurred shall be made by (i) counsel to the General Partner, with the concurrence of counsel to the Limited Partner, (ii) counsel to the Limited Partner, with the concurrence of counsel to

the General Partner or (iii) if counsel to the General Partner and the Limited Partner cannot concur, by a nationally recognized law firm with expertise in healthcare reimbursement jointly selected by the General Partner and the Limited Partner.

- 11.5. Promissory Note Portion of Purchase Price. Any promissory note delivered pursuant to this Article 11 shall be a non-negotiable promissory note payable in four (4) approximately equal annual installments of principal, commencing twelve (12) months after the closing, together with interest at a rate equal to the "index" or prime rate as published from time to time by Third National Bank in Nashville, Tennessee. The note shall contain provisions for (i) the acceleration of the entire unpaid balance of principal and accrued interest at the option of the holder in the event of default in payment of any principal or interest when due, (ii) the payment of reasonable attorneys' fees in the event of default, and (iii) prepayment, without penalty, of all or any part of the unpaid principal, any prepayment being first applied to then accrued interest. The note shall be secured by a first lien on the accounts receivable of the Center.
- 11.6. Stock Purchase Price of Limited Partner's Interest. If the General Partner or Partnership shall elect or be required to purchase the interest of a Limited Partner herein pursuant to Section 11.3 or 11.4 and elects to pay shares of the common stock of AmSurg Corp. (the "Shares"), such purchase price shall be determined and payable in the manner hereinafter set forth:
  - 11.6.1. The Limited Partner transferring its interest shall be paid Shares the value of which equals the portion of the purchase price to be paid by delivery of Shares.
    - 11.6.2. For purposes of determining the value of the Shares:
    - 11.6.2.1. If there exists an active trading market for the Shares, then (i) Shares listed on a registered securities exchange or the NASDAQ National Market System shall be valued at the average of the last sale price for the ten trading days preceding the date of determination; and (ii) Shares not so listed shall be valued at the average at their closing "bid" prices for the ten trading days preceding the date of determination.
    - 11.6.2.2. If no active trading market exists for the Shares, the Shares shall be valued by an investment banking firm that is a member of the New York Stock Exchange which is reasonably acceptable to the Limited Partner and the General Partner.

### 11.7. General Provisions.

- 11.7.1. All determinations of Partnership Profit required under Sections 11.3, 11.4 and 11.6 shall be made by the Partnership's regular independent certified public accountants utilizing accounting principles consistently applied and any such determination so made shall be binding on all parties. For the purpose of the computations required in determining the purchase price of the Limited Partner's interest in the Partnership, the books of the Partnership shall be accepted as correct.
- 11.7.2. If the Limited Partner's Partnership interest is acquired pursuant to Section 11.3 or 11.4, the Limited Partner will be distributed a pro rata share of the Available Cash Flow allocated to that Partnership interest for the month in which the General Partner or Partnership purchases its interest, based upon the number of days during such month prior to such purchase in relation to the total number of days in such month. Such distribution shall be made within 90 days after the end of such month.
- 11.7.3. No payment other than those specifically provided for herein shall be due or payable with respect to the interest of the Limited Partner. Any debt due by the Partnership to the Limited Partner shall be payable according to its terms.
- 11.7.4. The closing of the purchase of a Limited Partner's Partnership interest pursuant to this Article 11 shall be held at the principal office of the Partnership within thirty (30) days following the giving of written notice to the Limited Partner of the election to purchase such Limited Partner's interest in the Partnership. At the closing, the General Partner or Partnership, as the case may be, shall pay, upon the terms specified hereinabove, the determined value of such Limited Partner's interest to the Limited Partner, after receiving appropriate releases and satisfactions.
- 11.7.5. The General Partner may transfer or assign any of its rights to purchase the Partnership interest of the Limited Partner to the General Partner's Affiliates or assigns.

### 12. RESIGNATION, BANKRUPTCY OR DISSOLUTION OF THE GENERAL PARTNER

- 12.1. Resignation of the General Partner; Appointment of Substituted General Partner. Subject to the provisions of Sections 13.2 and 16.4 of this Agreement, the General Partner may resign and withdraw as such by written notice given in accordance with Section 12.2 of this Agreement.
- 12.2. Notice of Resignation. Written notice of the resignation of the General Partner or of any Substituted General Partner, as the case may be, shall be given by such entity to the Limited Partners. Such notice shall set forth the day upon which the resignation is to become

effective, which date shall not be less than 30 days after such notice is given to the parties being notified.

- 12.3. Bankruptcy or Dissolution of General Partner. If an order for relief is entered in behalf of or against the General Partner under Chapter 7 of Title 11, United States Code, such order for relief shall be deemed a resignation of the General Partner for purposes of Section 16.4 hereof. If an order for relief is entered in behalf of or against the General Partner under Chapter 11 of Title 11, United States Code, the General Partner shall continue to serve as the General Partner of the Partnership and such order for relief shall not be deemed an event of withdrawal of the General Partner. The dissolution of the General Partner shall be deemed a resignation of the General Partner under Section 16.4 of this Agreement.
- 12.4. Election of Substituted General Partner. If the General Partner resigns pursuant to this Agreement or is deemed to have resigned under Section 12.3, the Limited Partner may elect a Substituted General Partner in a writing signed by the Limited Partner. Such election must occur before the effectiveness of such resignation. The person so elected shall not become a General Partner until such resignation is effective, the person so elected has reached an agreement with the General Partner to purchase the General Partner's interest in the Partnership and such person has executed an amended Certificate of Limited Partnership as required by the Act. The Substituted General Partner will succeed to the interest of the resigning General Partner in the net income or net loss and the Available Cash Flow of the Partnership, except that the resigning General Partner shall be entitled to receive the amounts specified in Section 16.3.
- 12.5. Occurrences Which Are Not Events of Withdrawal by a General Partner. Except as provided in Section 12.3 hereof, the following events shall not constitute a withdrawal of a General Partner:
  - 12.5.1. Making an assignment for the benefit of creditors;
  - 12.5.2. Filing a petition seeking for the General Partner any reorganization, arrangement, composition, readjustment, liquidation, dissolution, or similar relief under any statute, law or regulation;
  - 12.5.3. Filing an answer or other pleading admitting or failing to contest the material allegations of a petition filed against the General Partner in a proceeding described in Section 12.5.3;
  - 12.5.4. Seeking, consenting to, or acquiescing in the appointment of a trustee, receiver, or liquidation of the General Partner of all or any substantial part of its properties; or
  - 12.5.5. The continuation of any proceeding against the General Partner seeking reorganization, arrangement, composition, readjustment, liquidation, dissolution, or similar relief under any statute, law, or regulation, for 120 days after the

commencement thereof or the appointment of a trustee, receiver, or liquidator for the General Partner or all or any substantial part of its properties without its agreement or acquiescence.

### 13. DISSOLUTION AND WINDING UP OF THE PARTNERSHIP

- 13.1. <u>Dissolution of the Partnership</u>. The resignation (or deemed resignation) and withdrawal of the General Partner shall cause a dissolution of the Partnership unless, prior to the effectiveness of the resignation, a Substituted General Partner shall be elected to continue the business of the Partnership subject to all the terms of this Agreement. The Partnership shall also be dissolved upon the expiration of the term of the Partnership.
- 13.2. Winding Up of the Partnership. Upon the dissolution of the Partnership, the General Partner shall take full account of the Partnership's assets and liabilities and the assets shall be liquidated as promptly as is consistent with obtaining the fair value thereof. The proceeds therefrom, to the extent sufficient therefor, shall be applied and distributed as provided in the Act; provided, however, that after payment of or creating adequate reserves to provide for all Partnership debts, obligations and liabilities, the assets of the Partnership which are distributed in kind to the Partners, if any, shall be treated as if sold for their fair market value and allocations and distributions shall be made pursuant to Section 8.3 hereof. All Partnership assets shall be distributed by the later of (i) the last day of the tax year of the liquidation as defined in Treasury Regulation 1.704(b) or (ii) 90 days after the liquidation.

### 14. BOOKS OF ACCOUNT, ACCOUNTING, REPORTS, FISCAL YEAR, BANKING AND TAX ELECTION

- 14.1. Books of Account. The Partnership's books and records (including a current list of the names and addresses of all Limited Partners) and an executed copy of this Agreement, as currently in effect, shall be maintained at the principal office of the Partnership in Tennessee, and each Partner shall have access thereto at all reasonable times. The books and records shall be kept by the General Partner using an appropriate method of accounting consistently applied and shall reflect all Partnership transactions and be appropriate and adequate for the Partnership's business. The General Partner shall also keep adequate federal income tax records using an appropriate method of accounting applied on a consistent basis.
- 14.2. Financial Reports. As soon as reasonably practicable after the end of each fiscal year, but not later than 90 days after the end of each fiscal year, an unaudited balance sheet of the Partnership at the end of the previous fiscal year and unaudited statements of income or loss of the Partnership for such year shall be made available to each Partner. In addition, the Partnership will make available to the Limited Partners unaudited monthly summaries of its operations. All such financial statements shall be prepared on an accrual basis of accounting in accordance with generally accepted accounting principles consistently applied. The Partnership

shall also furnish to each Partner not later than 90 days after the end of each fiscal year whatever information may be necessary for Partners to file their federal income tax returns. The Partnership will also make available to each Partner upon request a copy or summary of all state and/or local tax returns which are filed by the Partnership.

- 14.3. <u>Banking</u>. All funds of the Partnership shall be initially deposited in a separate bank account or accounts or in an account or accounts of a savings and loan association as shall be determined by the General Partner, but such funds may be invested as provided in Section 9.1.6 of this Agreement.
- 14.4. <u>Tax Election</u>. Upon the transfer of an interest in the Partnership or in the event of a distribution of the Partnership's property, the Partnership may, but is not required to, elect pursuant to Section 754 of the Code, to adjust the basis of the Partnership's property as allowed by Sections 734(b) and 743(b) thereof. The General Partner shall have the sole authority and discretion to make such an election. There shall be no requirement that the General Partner make such an election.
- 14.5. <u>Tax Returns</u>. The General Partner shall, for each fiscal year, file on behalf of the Partnership with the Internal Revenue Service a Partnership Return within the time prescribed by law (including any extensions) for such filing. The General Partner shall also file on behalf of the Partnership such state and/or local income tax returns as may be required by law.

### 15. POWER OF ATTORNEY

- 15.1. Appointment of Attorney-in-Fact. The Limited Partner hereby makes, constitutes and appoints the General Partner, with full power of substitution and resubstitution, his agent and attorney-in-fact to sign, execute, certify, acknowledge, and file for record any instruments which may be required by law of the Partnership or of the Limited Partner, including, but not limited to, amendments to this Agreement as permitted by Section 17.3 hereof and amendments to the Certificate of Limited Partnership. The Limited Partner authorizes such attorney-in-fact to take any further action which such attorney in-fact shall consider necessary or advisable in connection with the foregoing, hereby giving such attorney-in-fact full power and authority to act to the same extent as if the Limited Partner were itself personally present, and hereby ratifying and confirming all that such attorney-in-fact shall lawfully do or cause to be done by virtue hereof.
- 15.2. <u>Effect of Power</u>. The power of attorney granted pursuant to Section 15.1 of this Agreement:
  - 15.2.1. is a special power of attorney coupled with an interest and is irrevocable; and

15.2.2. shall survive the delivery of an assignment by the Limited Partner of the whole or a portion of its interest in the Partnership, except that where the purchaser, transferee or assignee thereof is to be admitted as a substituted Limited Partner, the power of attorney shall survive the delivery of such assignment for the sole purpose of enabling such attorney-in-fact to execute, acknowledge and file any agreement, certificate, instrument, or document necessary to effect such substitution.

### 16. LIABILITY OF THE GENERAL PARTNER

- 16.1. Return of Capital Contribution. Anything in this Agreement to the contrary notwithstanding, the General Partner shall not be individually liable for the return of the Capital Contributions of the Limited Partner, or any portion thereof, it being expressly understood that any such return shall be made solely from Partnership assets.
- 16.2. No Liability for Actions. The General Partner and its Affiliates shall have no liability to the Partnership or to any Partner for any loss suffered by the Partnership or any Partner which arises out of any action or inaction of the General Partner or its Affiliates or for breach of its fiduciary duty if the General Partner or its Affiliates acted in good faith and in a manner it believed to be in the best interest of the Partnership, provided, however, the General Partner and its Affiliates shall not be relieved of liability for (1) breach of the duty of loyalty to the Partnership or its Partners, (2) acts or omissions which involve intentional misconduct or a knowing violation of law, or (3) any distribution made in violation of this Agreement.
- 16.3. Indemnification. The Partnership shall indemnify, and upon request shall advance expenses to, in the manner and to the full extent permitted by law, the General Partner and its Affiliates against any losses, judgments, liabilities, expenses and amounts paid in settlement of any claims sustained by them in connection with the Partnership, except for those losses, judgments, liabilities, expenses and amounts paid in settlement of any claims sustained by them where it is estimated that (1) the General Partner failed to act in good faith, (2) the General Partner knew (a) in the case of conduct in its official capacity with the Partnership, that its conduct was not in the Partnership's best interest and (b) in all other cases, that its conduct was opposed to the best interests of the Partnership and (3) in the case of any criminal proceeding or action for civil penalties, the General Partner had reasonable cause to believe its conduct was unlawful. To the full extent permitted by law, the indemnification and advances provided for herein shall include expenses (including attorney's fees), judgments, fines and amounts paid in settlement. To the full extent permitted by law, the Partnership may maintain insurance on behalf of the General Partner or its Affiliates against any liability which may be asserted against such person. The indemnification and advancement of expenses granted pursuant to this Section, shall not be deemed exclusive of any other rights to which the General Partner or its Affiliates may be entitled; provided, however, that no indemnification may be made to or on behalf of the General Partner or its Affiliates if a judgment or other final adjudication adverse to the General Partner or its Affiliates establishes liability: (1) for any breach of the duty of loyalty to the

Partnership or its Partners; (2) for acts or omissions which involve intentional misconduct or a knowing violation of law; or (3) for any distribution made in violation of this Agreement.

16.4. Liability of the General Partner after Resignation. If the General Partner resigns in accordance with the provisions of this Agreement or is deemed to have resigned under Section 12.3, its liability as a general partner shall cease and the Partnership shall promptly take all steps reasonably necessary under the Act to cause such cessation of liability; provided, however, that if the Limited Partners do not elect a substitute General Partner, the General Partner shall remain the General Partner of the Partnership for purposes of the winding up of the Partnership pursuant to Section 13.2 of this Agreement. Upon such resignation, the General Partner shall receive its Capital Account as of the date of its resignation plus any unpaid Available Cash Flow allocated to its Capital Account.

### 17. AMENDMENTS

- 17.1. <u>Proposal of Amendments</u>. Amendments to this Agreement may be proposed by the General Partner or the Limited Partner.
- 17.2. <u>Adoption of Amendments</u>. A proposed amendment shall be adopted and effective as an amendment to this Agreement if it receives the affirmative vote of the General Partner and the Limited Partner.
- 17.3. Amendments Without Consent of Limited Partners. In addition to any amendments otherwise authorized herein, the General Partner may, without obtaining the consent of the Limited Partners, amend this Agreement from time to time:
  - (a) To add to the representations, duties or obligations of the General Partner or its Affiliates or surrender any right or power granted to the General Partner or its Affiliates herein, for the benefit of the Limited Partner; or
  - (b) To cure any ambiguity, to correct or supplement any provision herein which may be inconsistent with any other provision herein, or to make any other provisions with respect to matters or questions arising under this Agreement, which will not be inconsistent with the provisions of this Agreement, provided that the Partnership receives a written opinion of independent counsel that such amendment does not adversely effect the interests of the Limited Partner; or
  - (c) As necessary in the opinion of counsel to the Partnership for the allocations of taxable income and loss contained herein to be respected for federal income tax purposes; provided, that no such amendment shall materially increase the obligations of the Limited Partner hereunder or materially dilute its rights under this Agreement; or
  - (d) Upon advice of counsel that the operations of the Partnership are in violation of law, to cause this Agreement to comply with the law; provided, however,

such amendments shall not alter materially the economic objectives of the Partnership and, further, provided that any amendment to or deletion of any provision in Article 11 hereof shall not materially reduce the economic return to the Limited Partner.

### 18. MEETINGS

- 18.1. Call of Meetings. There will be an annual meeting of the Partners held within 120 days after the end of the Partnership's fiscal year upon call by the General Partner. Other meetings of the Partners may be called by the General Partner, or the Limited Partner. The General Partner shall also call a meeting of the Partners to be held not later than 60 days following the receipt by the General Partner of any notice of adjustments of Partnership income or expenses issued by the Internal Revenue Service in connection with an audit of any Partnership Return, such meeting to determine the appropriate action to be taken, including without limitation, the forum of any litigation contesting the notice. The call for any meeting called under this Article 18 shall state the nature of the business to be transacted.
- 18.2. Notice of Meetings. Notice of each meeting of the Partners shall be delivered by the General Partner within ten days of its calling to all Partners in the manner prescribed in Section 19.1 of this Agreement and such meeting shall be held not less than 15 days nor more than 60 days after such notice.
- 18.3. <u>Voting by Partners</u>. Partners may vote in person or by proxy at any such meeting. Whenever the vote or consent of Partners is permitted or required under this Agreement, such vote or consent may be given at a meeting of Partners or may be given in writing. For purposes of obtaining a written vote, the General Partner may require response within a specified time, but not less than 15 days, and failure to respond shall constitute a vote which is consistent with the General Partner's recommendation with respect to the proposal.

### 19. MISCELLANEOUS

19.1. Notices. Except as otherwise provided in this Agreement, any notice, payment, demand or communication required or permitted to be given by any provision of this Agreement shall be duly given (a) if delivered in writing personally to the person to whom it is authorized to be given, (b) if sent by certified or registered mail or telegraph, as follows: if to the General Partner, at its address set forth in the first paragraph of this Agreement, or to such other address as the General Partner may from time to time specify by written notice to the Limited Partners; and if to a Limited Partner, at such Limited Partner's address set forth in Annex A hereto, or to such other address as such Limited Partner may from time to time specify by written notice to the General Partner, or (c) if sent by electronic facsimile to (615) 385-5999 in the case of the General Partner or to such other number as the General Partner may provide to the Partnership or if to the Limited Partners to the facsimile numbers on the records of the Partnership. Any such notice shall be deemed to be given as of the date so delivered, if delivered personally, as

of the date on which the same was deposited in the United States mail, postage prepaid, addressed and sent as aforesaid or on the date received if sent by electronic facsimile.

- 19.2. <u>Section Captions</u>. Section and other captions contained in this Agreement are for reference purposes only and are in no way intended to describe, interpret, define or limit the scope, extent or intent of this Agreement or any provision hereof.
- 19.3. Termination of Non-Competition Provisions. In the event either the General Partner or AmSurg Corp., or their successors or assigns, (a) fails to perform any material term of this Agreement and such failure is not cured within thirty (30) days after receipt of written notification by a majority of the Limited Partners of such failure, or (b) is liquidated pursuant to any voluntary or involuntary creditors' proceeding under the federal bankruptcy laws or the insolvency laws of any other jurisdiction, the provisions of Section 10.1 hereof applicable to the Limited Partner and any of its partners shall terminate and be of no further force or effect.
- 19.4. <u>Severability</u>. Every provision of this Agreement is intended to be severable. If any term or provision of this Agreement is illegal or invalid for any reason whatsoever, such illegality or invalidity shall not affect the validity of the remainder of this Agreement.
- 19.5. <u>Tennessee Law</u>. The laws of the State of Tennessee shall govern the validity of this Agreement, the construction of its terms and the interpretation of the rights and duties of the parties hereto.
- 19.6. <u>Waiver of Action for Partition</u>. Each Partner irrevocably waives during the term of the Partnership and during the period of its liquidation following any dissolution, any right to maintain any action for partition with respect to any of the assets of the Partnership.
- 19.7. <u>Counterpart Execution</u>. This Agreement may be executed in one or more counterparts all of which together shall constitute one and the same Agreement.
- 19.8. Parties in Interest. Except as provided in Article 11 of this Agreement, this Agreement shall be binding upon the parties hereto and their successors, heirs, devisees, assigns, legal representatives, executors and administrators.
- 19.9. Construction of Pronouns. The feminine or neuter of the words "he," "his" and "him" used herein shall be automatically deemed to have been substituted for such words where appropriate to the particular Limited Partner executing this Agreement.
- 19.10. <u>Integrated Agreement</u>. This Agreement constitutes the entire understanding and agreement among the parties hereto with respect to the subject matter hereof, and there are no agreements, understandings, restrictions, representations or warranties among the parties other than those set forth herein or herein provided for. The parties acknowledge that they have independently negotiated the provisions of this Agreement, that they have relied upon their own counsel as to matters of law and application and that neither party has relied on the other party

with regard to such matters. The parties expressly agree that there shall be no presumption created as a result of either party having prepared in whole or in part any provisions of this Agreement.

IN WITNESS WHEREOF, this Agreement of Limited Partnership has been executed as of the date first above written.

GENERAL PARTNER:

AmSurg KEC Inc.

Title

LIMITED PARTNER:

The Endoscopy Center

Title:

147179

## ANNEX A (to the Agreement of Limited Partnership The Endoscopy Center of Knoxville, L.P.)

### LIMITED PARTNER

Name, Address and Taxpayer Identification Number

Partnership Interest

The Endoscopy Center 801 Weisgarber Road Suite 100 Knoxville, TN 37950-9002 49%

62-1494764

### FIRST AMENDMENT TO AGREEMENT OF LIMITED PARTNERSHIP OF THE ENDOSCOPY CENTER OF KNOXVILLE, L.P.

WHEREAS, effective as of November 30, 1992, AmSurg KEC, Inc., as general partner, and The Endoscopy Center as limited partner, entered into an Agreement of Limited Partnership (the "Agreement"); and

WHEREAS, the intent of the parties to the Agreement of Limited Partnership was that the General Partner would receive amortization and depreciation deductions for income tax purposes based solely on the General Partner's tax basis in the 51% undivided interest in the assets comprising the Center which the General Partner contributed to the Partnership as though such undivided interest had continued to be held by the General Partner outside the partnership; and

WHEREAS, the intent of the parties to the Agreement of Limited Partnership was that the Limited Partner would receive amortization and depreciation deductions for income tax purposes based solely on the Limited Partner's tax basis in the 49% undivided interest in the assets comprising the Center which the Limited Partner contributed to the Partnership as though such undivided interest had continued to be held by the Limited Partner outside the partnership; and

WHEREAS, the Agreement as signed may not accomplish the objectives above and the General Partner and the Limited Partner desire to have the Agreement clearly reflect their mutual intent and understanding.

NOW, THEREFORE, the parties agree to amend Section 8.2 of the Agreement, effective November 30, 1992, to provide as follows:

- 8.2 <u>Allocations to Reflect Contributed Property</u>. If a Partner contributes property other than cash to the Partnership, the following rules shall apply:
- 8.2.1 Except as provided in Section 8.2.2., if a Partner contributes property to the Partnership which has a difference between its tax basis and its fair market value on the date of its contribution, then all items of income, gain, loss and deduction with respect to such contributed property shall be shared for federal income tax purposes among the Partners pursuant to Section 704(c) of the Code so as to take into account the variation between the basis of such property and its fair market value at the time of contribution.

8.2.2 With regard to the undivided interests in the assets comprising the business of the Center contributed by the Partners pursuant to Section 6.1 (including accounts receivable), depreciation, amortization, or gain or loss with respect to such undivided interests shall be determined in the same manner as if such undivided interests continued to be held by the Partners outside the Partnership. This allocation provision is intended to incorporate the principles stated in Treasury Regulation Section 1.704-1(c)(3) and is intended by the Partners to apply regardless of whether there is a change in the Partner's respective interest in capital, as illustrated in Treasury Regulation Section 1.704-1(c)(3)(ii) example 2.

IN WITNESS WHEREOF, this Amendment to Agreement of Limited Partnership has been executed this \_\_\_\_\_ day of March, 1993, effective as of November 30, 1992.

LIMITED PARTNER:

GENERAL PARTNER:

The Endoscopy Center

Amsurg KEC, Inc.

By: Dergein - Werliell Title: Pres.

By: Title

0343y

### EGERTON, Meafee, ARMISTEAD & DAVIS, P.C.

ATTORNEYS AT LAW BIVEKVIEW TOWAK YOU SOUTH GAY STREET Sulta Jadi Post oppice box 2047

WM W DAVIS NE MONT MEATER LEVIS C FOSTER IR WM W DAVIS, IL HERBERTH SLATERY, III BARRY K MAXWELL STEPHEN A MISSIES WILLIAM E NICLAMBOCK III KOCKFORDE D KING JONATHAN D REED RONALDI HILL KEUMENN PELDI, IV WESLEY L HATMAKER MARY JAME BOKUEN CHEKYL CILLEY RICE A CHRISTOPHER TRUMP

KNOXVILLE, TENNESSEE 37301-2047

JOE M MCAFEE E-Mail Address: practice@emudlaw.com

May 24, 2004

AKEA CODE 865 TELEPHONE 54b-D500 FACSIMILE

JOSEPH A MANPEE (1903-1984) M W ECERTON, JR (1925-1994) J M ARMISTEAD (1912-2007)

WWW EMADLAW COM

Via Telefax & U.S. Mail (615) 742-2773

T. Scott Noonan, Esq. Bass, Berry & Sims AmSouth Center, Suite 2700 315 Deaderick Street Nashville, TN 37238-3001

> The Endoscopy Center of Knoxville, L.P. Re:

Dear Scon:

I am faxing herewith the signature pages on the Third Amendment to the Amended and Restated Agreement of Limited Partnership of the Endoscopy Center of Knoxville, L.P., the signature pages on the Right of First Refusal Agreement, and the signature page on the Management Services Agreement. We only got the original signatures of the various parties on one original of each document; however, we can live with copies of the three documents with copied signature pages and you may retain the only original if that is your preference. I will forward the original signature pages to by regular mail. Please fax to me one executed signature page for AmSurg, and mail to me two copies of the completed documents.

Please do not hesitate to give me a call if you have any questions concerning the foregoing.

Personal regards.

JMM;kdh Enclosures

cc:

Mr. Jeff Dew

P. S. Please Complete Notice Provisions in the ew agramants with a copy to me

002534\NOONAN LTK 2004-05 24

### EGERTON, McAFEE, ARMISTEAD & DAVIS, P.C.

ATTURNEYS AT LAW RIVERVIEW TOWER YOU SOUTH GAY STREET SUITE 1400 POST OFFICE BOX 2017

WM W DAYIS IDE MONT MAFER LEWIS C FOSTEK IK WM W DAVIS, IR HERBERT H SLATERY, III BARRY & MAXWELL STEPHEN A MOSWELN WILLIAM & MCCLAMMOCH III ROCKFORDED KING IONATHAND KEED MONALD T HILL KEUHEN'N PELOT, IV WESLEY & HATMANEIL MARY JANE BURDEN CHEKAT DIFTER HICE

R CURLITOPIER TRUMP

KNOXVILLE TEXNESSEE 37401-3047

JOE M MCAFEE EMBI Address jmosfec@omidiaw.com

May 25, 2004

AREA CODE BOS TELEPHONE SHO \$40-0500 FACTIMILE 325-3293

(P861-1061) BERASM A HEBEOL W M' ECETILON' 1K" (1757-1704) J M ARMISTEAD (1913-2103)

> Websets WINW ENTABLAW COM

Via Telefax & U.S. Mail (615) 742-2773

T. Scott Noonan, Esq. Bass, Berry & Sims AmSouth Center, Suite 2700 315 Deaderick Street Nashville, TN 37238-3001

> The Endoscopy Center of Knoxville, L.P. Re:

Dear Scott:

I am faxing herewith a revised signature page for the Third Amendment to the Amended and Restated Agreement of Limited Partnership of the Endoscopy Center of Knoxville, L.P., specifically reflecting the signature of Sarkis Chobanian, who executed the document as a Partner in The Endoscopy Center. Also, a signature page for the Right of First Refusal Agreement reflecting the signature of Sarkis Chobanian as a Partner in The Endoscopy Center is enclosed. This should completer our original signature pages on the three documents. I assume after you receive these two revised signature pages you will fax to me a copy of the documents reflecting the signature thereon of AmSurg.

Personal regards.

McAfee, Esq.

JMM;kdh Enclosures

CC:

Mr. Jeff Dew 002534\NOONAN LIK 2004-05 25

## EGERTON, MAFEE, ARMISTEAD & DAVIS, P.C.

ATTORNEYS AT LAW
ATTORNEYS TAWAR
RIVERVIEW TOWER
ETTER
STITE TOWN
FOR TOWNEY ATTORNEY
FOR TOWNEY
F

WM W DAVIS
JOE MONT MEATER
LEWIS C POSTEK, JR
WM W DAVIS, JR
HERBERT H SLATERY, ILI
HARKY E. MANWELL
STUPHEN A MEMERA
WILLIAM E. MCCLADROCH ILI
KOCKPORDE D. KANG
JONATHAN D. BEHLI
KOMALD T. MILL
HILLERN N. PELOT, IV
WESLEY E. MATSALER
MALY JAME BORDEN

CHERTL ON LEY MICE K CHMISTOPHER TRUMP JOE M McAFEE
E-Mail Address Jimenlon@contacted.com

May 24, 2004

AKCA CODE 865
TELEPHONE \$40-0500
FACSIMILE \$23-5293

1050PH A MEAFEE (1903-1914) M W EGERTON, IK (1935-1984) J M ARMIS) (AD (1913-2002)

> Water WWW EMADLAW COM

Via Telefax & U.S. Mail (615) 742-2773

T. Scott Noonan, Esq. Bass, Berry & Sims AmSouth Center, Suite 2700 315 Deaderick Street Nashville, TN 37238-3001

Re: TEC North, LLC

Dear Scott:

Please be advised that I did the legal work in connection with the establishment of TEC North, LLC, a Tennessee limited liability company. Dr. B.F. Overholt is the Chief Manager of TEC North, LLC, and has the authority to execute and bind the LLC to the terms and provisions of the Third Amendment to the Amended and Restated Agreement of Limited Partnership of The Endoscopy Center of Knoxville, L.P., the Right of First Refusal Agreement, and the Management Services Agreement, all of which involve the ambulatory surgery center on Emory Road in Powell, Tennessee.

Personal regards.

Jos M. McAfee, Esq.

JMM;kdh Enclosures

c: Mr. Jeff Dew

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A.5--Management Contract

## MANAGEMENT SERVICES AGREEMENT

This agreement ("Agreement") is entered into this 30th day of November, 1992, (the "Effective Date") by and between The Endoscopy Center of Knoxville, L.P., a Tennessee limited partnership ("LP") and AmSurg Corp., a Tennessee Corporation ("Manager").

WHEREAS, LP owns and operates an ambulatory surgical treatment center in Knoxville, Tennessee at 801 Weisgarber Road ("Center"); and

WHEREAS, LP desires to operate the Center in a manner consistent with the efficient and appropriate utilization of health care resources and high standards of quality; and

WHEREAS, Manager is in the business of managing ambulatory surgical treatment centers and LP wishes to utilize the expertise of Manager in the operation of the Center; and

WHEREAS, Gastrointestinal Associates, P.C. ("PC") is a professional corporation and group practice which employs physicians who are well qualified, competent and licensed to practice medicine in Tennessee; and

WHEREAS, LP desires Manager to oversee and administer the business operations of the Center and Manager desires to provide such services to LP pursuant to this Agreement;

NOW THEREFORE, in consideration of the premises and the mutual promises and covenants contained herein, LP and Manager do hereby agree as follows:

## I. ENGAGEMENT

LP engages the services of Manager and Manager agrees to provide such services upon the terms and conditions hereinafter set forth.

## II. NATURE OF RELATIONSHIP

2.1 Manager shall perform all services described in Section III hereof for the account of and as agent of LP. LP hereby appoints the Manager its attorney-infact with full power on its behalf and in its name, or in the name of the Center, (a) to prosecute or defend any litigation or proceeding before any governmental agency arising out of the operation of the Center, and (b) to enter into contracts in the ordinary course of the Center's business; provided, however, that Manager shall not obligate LP to any indebtedness in excess of \$20,000 for any one item or transaction without the express written consent of LP, which consent shall not be unreasonably withheld.

2.2 Notwithstanding any provision to the contrary, the authority of Manager to manage the operation of the Center shall be subject to the ultimate control of the governing body of the Center. Moreover, the direction and coordination of all medical aspects of Center programs shall be under the direction and control of the Medical Director, as provided under the Administrative and Ancillary Services Agreement, attached hereto as Exhibit A.

## III. MANAGEMENT SERVICES

Manager shall have the responsibility to supervise, consult in and oversee the business and administrative operation of the Center and, subject to the terms of this Agreement and the general direction and control of LP, shall have the responsibility for supervising and coordinating all business and administrative activities of the Center (other than those physician services rendered to LP by PC pursuant to Exhibit A), including, but not limited to, the following:

- 3.1 Assist the Center to be operated in an efficient and business like manner;
- 3.2 Effect the purchase or lease of equipment, supplies and pharmaceuticals deemed by the Advisory Board of the LP to be necessary for the operation of the Center:
- 3.3 Coordinate all reasonable and necessary actions to maintain all licenses, permits and certificates required for the operation of the Center, and to obtain all appropriate certification and accreditation available to the Center's operations;
- 3.4 Coordinate, together with PC and the Advisory Board of LP, ongoing community education programs that address the health care questions, concerns and issues important to patients and their families;
- 3.5 Negotiate, together with the LP and the PC, the amount and method of reimbursement that the Center will receive from all appropriate third-party payors, both public and private;
- 3.6 Establish, maintain, revise and administer, together with the LP and the PC, the overall charge structure of the Center and arrange for payment of such charges by others, when appropriate;
- 3.7 Oversee, direct and manage the personnel provided by PC pursuant to Exhibit A in performing accounting and bookkeeping services for the LP in the operation of the Center, including but not limited to, all actions necessary to (1) maintain the books of account, including all journals and ledgers, check register and payroll records, (2) post all patient and other charges, including

necessary analyses and corrections, (3) establish adequate receivable, credit and collection policy and procedures, (4) process vendors' invoices and other accounts payable, (5) prepare monthly bank reconciliations, and (6) establish patient direct pay and insurance billing procedures;

- 3.8 Develop and revise all necessary policies and operating procedures pertaining to business and administrative aspects of the Center's operations;
- 3.9 Hire, supervise, discipline and discharge all employees of the L.P., as needed, and together with the PC, supervise and direct the nonphysician employees of PC, who work in the Center;
- 3.10 Assist the PC to establish, revise and administer wage scales, benefits, rates and conditions of employment, staffing schedules and personnel policies for all nonphysician personnel primarily involved in the operation of the Center;
- 3.11 Arrange for the purchase by LP of necessary insurance coverage for the Center;
- 3.12 Establish and administer accounting procedures and controls and systems for the development, preparation, and keeping of records and books of accounting relating to the business and financial affairs of the Center;
- 3.13 Oversee and direct the preparation of, in a timely manner, the annual report and income tax returns required to be filed by the Center, and deliver a copy of same to LP's partners in a timely manner as needed; furnish LP in a timely fashion monthly operating reports and other reports reasonably requested by the LP;
- 3.14 Assist LP and PC as necessary and as requested to maintain effective quality assurance and utilization review programs in the Center, pursuant to Exhibit A; and
- 3.15 Perform all duties herein required of it in good faith and with reasonable diligence so as to assure that the Center efficiently provides appropriate quality health care to patients.

## IV. COMPENSATION FOR SERVICES RENDERED BY MANAGER

- 4.1 For all services rendered by the Manager under this Agreement, LP shall pay the Manager a fee equal to 2.5% of the net revenues of LP to be paid monthly in arrears.
- 4.2 In addition, LP shall reimburse Manager on a monthly basis for its direct expenses incurred in connection with marketing, promotional, business development and regulatory activities directly benefitting the Center. Manager shall prepare an itemization of such out-of-pocket expenses on a monthly basis to be submitted to LP by the 15th of the subsequent month.

## V. TERM

The initial term of this Agreement shall be for three years from the Effective Date (the "Initial Term"). The Agreement shall be renewable by LP at its option for three additional consecutive three-year terms after the Initial Term, on the same terms, conditions and provisions as contained herein, together with any authorized and approved amendments hereto.

## VI. DEFAULT AND TERMINATION

Either party shall be in default of this Agreement if it fails to perform any material term thereof or any amendments thereto, and such failure is not cured within thirty (30) days after receipt of written notification from the party not in default of such failure. In the event of such default, the nondefaulting party shall have the right to terminate this Agreement immediately by written notice to the other party.

## VII. ASSIGNMENT

Manager may freely assign its rights and duties under this Agreement to a related or successor entity. Upon any such assignment, all references to Manager in this Agreement shall be deemed to include such assignee.

## VIII. ARBITRATION

All disputes relative to this Agreement shall be resolved by arbitration pursuant to the rules of the American Arbitration Association then pertaining.

## IX. RIGHTS CUMULATIVE; NO WAIVER

Any rights or remedies of either party in the event of default are intended to be cumulative rather than exclusive. Moreover, if either party chooses not to insist upon strict performance of any provision of this Agreement, such choice shall not impair its rights to insist on strict performance in the event of subsequent acts of default and the waiver by a party of any breach of any provision of the Agreement by the other party shall not operate or be construed as a waiver of any subsequent breach by that party.

## X. ACCESS TO BOOKS AND RECORDS OF CENTER BY GOVERNMENT OFFICIALS

Upon written request of the Secretary of Health and Human Services or the Comptroller General or their duly authorized representatives, Manager or any other related organization providing services with a value or cost of Ten Thousand Dollars (\$10,000) or more over a twelve-month (12-month) period, shall make available to the Secretary, or other authorized official, the contract, books, documents, and records that are necessary to certify the nature and extent of the cost of providing such services. Such inspection shall be available up to four (4) years after such services are rendered.

## XI. NOTICE

Any notice required or permitted to be given under this Agreement shall be in writing and shall be deemed to have been properly made and delivered when mailed by first class, postage prepaid, certified or registered mail, or overnight courier services as follows:

If to Manager:

AmSurg Corp.
2301 21st Avenue South
Suite 300
Nashville, Tennessee 37212
Attn: President

If to LP:

The Endoscopy Center of Knoxville, L.P. 2301 21st Avenue South Suite 300
Nashville, Tennessee 37212
Attn: General Partner

or to such other person and address as either party may designate in writing.

## XII. MISCELLANEOUS

## 12.1 Authorization for Agreement

The signing and performance of this Agreement has been duly and validly authorized, executed and delivered by LP and Manager and this Agreement constitutes the valid and enforceable obligations of the parties in accordance with its terms.

## 12.2 Complete Agreement--Severability

- A. This instrument contains the entire agreement between the parties with respect to the subject matter hereof. All prior negotiations and understandings are merged herein. This Agreement may not be modified unless agreed to in a writing signed by both parties hereto.
- B. Should any part of this Agreement be declared invalid by a court or regulatory body of competent jurisdiction, such decision shall not affect the validity of the remaining parts, and they shall remain in full force and effect.

## 12.3 Applicable Laws

This Agreement shall be construed and enforced according to the laws of Tennessee.

## 12.4 No Presumption Created

The parties acknowledge that they have independently negotiated the provisions of this Agreement, that they have relied upon their own counsel as to matters of law and application and that neither party has relied on the other party with regard to such matters. The parties expressly agree that there shall be no presumption created as a result of either party having prepared in whole or in part any provisions of this Agreement.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their fully authorized representatives as of the day and year first above written.

AmSurg Corp.

1)

The Endoscopy Center of Knoxville, L.P.

By: Amsurg KEC, Inc.

Title: General Partner

Title

148918.03

## FIRST AMENDMENT TO MANAGEMENT SERVICES AGREEMENT

This First Amendment ("First Amendment") to the Management Services Agreement ("Agreement") dated November 30, 1992 by and between The Endoscopy Center of Knoxville, L.P., a Tennessee limited partnership ("LP") and AmSurg Corp., a Tennessee corporation ("Manager"), is made and entered into effective as of <u>Seprl</u>, 1997.

## WITNESSETH:

WHEREAS, LP and Manager executed the Agreement effective November 30, 1992; and

WHEREAS, the Agreement was renewed effective December 1, 1995; and

WHEREAS, pursuant to Section 4.1 of the Agreement, LP pays Manager a fee for services rendered under the Agreement; and

WHEREAS, the parties now desire to amend certain provisions of the Agreement regarding the fee paid to the Manager.

NOW, THEREFORE, in consideration of the foregoing and for other good and valuable consideration, the receipt of which is hereby acknowledged, the parties hereby amend the Agreement as follows:

- 1. Section 4.1 is hereby amended as follows:
  - "4.1 For all services rendered by the Manager under this Agreement, LP shall pay the Manager a fee equal to 2% of the net revenues of LP to be paid monthly in arrears; provided, however, that in no event will the fee payable hereunder exceed \$50,000 in any one year."

Defined terms not otherwise defined herein shall have the meaning set forth in the Agreement. All other provisions of the Agreement shall remain in full force and effect as on the date hereof.

IN WITNESS WHEREOF, this First Amendment to the Agreement is effective as of the date first above written.

AMSURG CORP.

Rose

THE ENDOSCOPY CENTER OF KNOXVILLE, L.P.

By: AmSurg KEC, Inc. Title: General Partner

By: Clam Sn. greni
Title: VP

Bergein F. Ourlish

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## SECOND AMENDMENT TO MANAGEMENT SERVICES AGREEMENT

This Second Amendment (the "Amendment") to the Management Services Agreement (the "Agreement") is executed as of the 1<sup>st</sup> day of May, 2002 by and between The Endoscopy Center of Knoxville, L.P., a Tennessee limited partnership ("LP"), and AmSurg Corp., a Tennessee corporation ("Manager").

## WITNESSETH:

WHEREAS, LP and Manager entered into the Agreement effective November 30, 1992, which was amended effective September 1, 1997, and renewed for an additional three (3) year terms in 1995 and 1998; and

WHEREAS, the parties now desire to amend the Agreement to reflect additional ambulatory surgery centers to be owned by LP for which Manager will oversee and administer the business operations.

NOW, THEREFORE, in consideration of the premises and the mutual promises and covenants contained herein, LP and Manager do hereby agree as follows:

- 1. All references in the Agreement to the Center shall hereinafter refer to all ambulatory surgery centers owned and operated by LP, including the center located at 801 Weisgarber Road (the "Old Center"), and the new center to be developed on the Fort Sanders west campus (the "New Center").
  - 2. Section 4.1 of the Agreement is hereby amended to read as follows:

"For all services rendered by the Manager under this Agreement, LP shall pay the Manager a fee equal to 2% of the net revenues of LP to be paid monthly in arrears; provided, however, that in no event will the fee payable hereunder exceed \$50,000 in any one year."

The second sentence of Section V of the Agreement is hereby amended to read as follows:

"This Agreement shall be renewed automatically for three (3) additional consecutive three (3) year terms after the Initial Term, on the same terms, conditions and provisions as contained herein, unless LP gives notice of non-renewal to Manager at least ninety (90) days prior to the expiration date of the previous term."

4. The addresses set forth in Section XI of the Agreement are hereby amended as follows:

Manager's address:

AmSurg Corp.

20 Burton Hills Boulevard Nashville, TN 37215 Attn: President

LP address:

The Endoscopy Center of Knoxville, L.P.

20 Burton Hills Boulevard Nashville, TN 37215 Attn: General Partner

5. Defined terms not otherwise defined herein shall have the meaning set forth in the Agreement. All other provisions of the Agreement, as amended, shall remain in full force and effect on the day hereof.

IN WITNESS WHEREOF, this Amendment to the Agreement is effective as of the date first above written.

AmSurg Corp.

By:

Title:

The Endoscopy Center of Knoxville, L.P.

a Tennessee limited partnership

By:

AmSurg KEC, Inc.,

Its General Partner

By:

Title

## RENEWAL OF MANAGEMENT SERVICES AGREEMENT

This Renewal ("Renewal") of the Management Services Agreement ("Agreement") is executed this <u>Total</u> day of <u>Ditabol</u>, 1998, by and between The Endoscopy Center of Knoxville, L.P., a Tennessee limited partnership ("LP") and AmSurg Corp., a Tennessee corporation ("Manager").

## RECITALS:

WHEREAS, LP and Manager entered into a Management Services Agreement effective November 30, 1992, which was amended effective September 1, 1997; and

WHEREAS, pursuant to the Agreement, LP engaged Manager to oversee and administer the business operations of the ambulatory surgery center owned and operated by LP; and

WHEREAS, pursuant to Article V of the Agreement, the Agreement is renewable by LP at its option for three (3) additional three (3) year terms; and

WHEREAS, the Agreement was renewed for a three (3) year term in 1995; and

WHEREAS, LP desires to renew the Agreement for an additional three (3) year term; and

WHEREAS, Manager desires to continue to perform its services under the Agreement for an additional three (3) year term;

NOW, THEREFORE, in consideration of the foregoing, LP and Manager hereby agree as follows:

- 1. Renewal. LP hereby renews the Agreement for an additional three (3) year term commencing December 1, 1998.
- 2. <u>Terms of Renewal</u>. The Agreement is renewed on the same terms, conditions and provisions as contained in the Agreement, as amended.
- 3. Acceptance by Manager. By execution of this Renewal, Manager hereby agrees to continue to perform its services under the Agreement, as amended.

IN WITNESS WHEREOF, the parties have caused this Renewal to be executed by their duly authorized representatives as of the day and year first above written.

## THE ENDOSCOPY CENTER OF KNOXVILLE, L.P.

Describes UP & asses Song.

By: AmSurg KEC, Inc. Title: General Partner

AMSURG CORP.

By: Pres

## THIRD AMENDMENT TO MANAGEMENT SERVICES AGREEMENT

This Third Amendment (the "Third Amendment") to the Management Services Agreement (the "Agreement") is entered into effective as of September 1, 2004 by and between The Endoscopy Center of Knoxville, L.P., a Tennessee limited partnership ("LP"), and AmSurg Corp., a Tennessee corporation ("Manager").

## WITNESSETH:

WHEREAS, LP and Manager entered into the Agreement effective November 30, 1992, which was renewed effective November 30, 1995, amended effective September 1, 1997, renewed effective December 1, 2001, and amended effective May 1, 2002; and

WHEREAS, the parties now desire to further amend the Agreement.

NOW, THEREFORE, in consideration of the premises and the mutual promises and covenants contained herein, LP and Manager do hereby agree as follows:

1. Section V ("Term") of the Agreement shall be deleted and replaced in its entirety with the following:

The initial term of this Agreement shall begin on November 30, 1992 and shall continue until November 29, 2007 (the "Initial Term"). The Agreement shall automatically renew for three (3) additional consecutive three (3) year terms (each a "Renewal Term") after the Initial Term, on the same terms, conditions and provisions as contained herein, unless either party gives written notice to the other party at least one huntired bighty (180) days prior to the expiration date of the then existing Initial Term or Renewal Term as the case may be.

AUTOMATICE
RENEWALS
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- 2. All defined terms used and not otherwise defined in this Third Amendment shall have the meaning given to them in the Agreement, as amended. All other terms and provisions of the Agreement, the First Amendment and the Second Amendment shall remain in full force and effect as on the date thereof. To the extent this Third Amendment is inconsistent with the Agreement, the First Amendment or the Second Amendment, this Third Amendment shall control.
- 3. Except as amended by this Third Amendment, the Agreement, as amended, shall remain in full force and effect.
- 4. This Third Amendment may be executed in counterparts, each of which shall be deemed an original, and all of which, taken together, shall constitute one complete document.

IN WITNESS WHEREOF, this Third Amendment to the Agreement is effective as of the date first above written.

**AmSurg Corp** 

The Endoscopy Center of Knoxville, L.P. a Tennessee limited partnership

AmSurg KEC, Inc., Its General Partner By:

MOR MANAGEMENT CONFERE

## RENEWAL OF ADMINISTRATIVE AND ANCILLARY SERVICES AGREEMENT

This Renewal ("Renewal") of the Administrative and Ancillary Services Agreement ("Agreement") is executed this 30 to day of 1995, by and between The Endoscopy Center of Knoxville, L.P., a Tennessee limited partnership ("LP") and Gastrointestinal Associates, P.C., a Tennessee professional corporation ("PC").

#### RECITALS:

WHEREAS, LP and PC entered into an Administrative and Ancillary Services Agreement effective November 30, 1992, which was amended effective February 1, 1993; and

WHEREAS, pursuant to the Agreement, LP engaged PC to provide certain administrative and professional services to the ambulatory surgery center owned and operated by LP ("Center"), including but not limited to the services of a medical director and certain non-physician personnel, and assistance in overseeing the Center's quality assurance and utilization review programs; and

WHEREAS, pursuant to Article XIV of the Agreement, the Agreement is renewable by LP at its option for three (3) additional three (3) year terms; and

WHEREAS, LP desires to renew the Agreement for an additional three (3) year term; and

WHEREAS, PC desires to continue to provide its services under the Agreement for an additional three (3) year term;

NOW, THEREFORE, in consideration of the foregoing, LP and PC hereby agree as follows:

- 1. Renewal. LP hereby renews the Agreement for an additional three (3) year term commencing December 1, 1995.
- 2. <u>Terms of Renewal</u>. The Agreement is renewed on the same terms, conditions and provisions as contained in the Agreement, as amended.
- 3. Acceptance by PC. By execution of this Renewal, PC hereby agrees to continue to provide its services under the Agreement.

IN WITNESS WHEREOF, the parties have caused this Renewal to be executed by their fully authorized representatives as of the day and year first above written.

THE ENDOSCOPY CENTER OF KNOXVILLE, L.P.

By: AmSurg KEC, Inc. Title: General Partner

By: Vice President of and, Sain

GASTROINTESTINAL ASSOCIATES, P.C.

By: BHU verliets
Title: For 5

0400679

**A.6--Site Control** 

## OPTION TO SUBLEASE

This Option to Sublease ("Option Agreement") is made and entered into effective as of the day of day

## Recitals

- A. Owner is the owner of improved real property located in the Dowell Springs development off Middlebrook Pike in Knoxville, Tennessee, more particularly known as Lot 4R3 as shown on that Final Plat of Dowell Springs Resubdivision of Lots 4R1, 4R2, 4R6 and J.P.E Meadowgreen Way of record as Instrument Number 201506190069904 in the Register's Office for Knox County, Tennessee ("Property"), upon which Owner intends to construct a 3-story building ("Building") containing approximately 50,000 square feet including medical office space and an ambulatory, outpatient endoscopy center ("Center").
- B. Upon completion of construction of the Building, Owner and Master Tenant have agreed that Owner will, pursuant to a master agreement, lease the entire Building and related improvements ("Project") to Master Tenant, and, in turn, Master Tenant has agreed to sublease shell space comprising the Center to Endoscopy Subtenant.
- C. Accordingly, the purpose of this Option Agreement is to grant to Endoscopy Subtenant the right and option to lease the Center upon the terms and conditions hereinafter set forth.

NOW THEREFORE, in consideration of these premises and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Owner and Endoscopy Subtenant do hereby agree as follows:

- 1. GRANT OF EXCLUSIVE OPTION. For good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged by the Parties, Owner and Master Tenant hereby unconditionally and irrevocably grant, bargain, sell and convey to Endoscopy Subtenant, the exclusive right and option ("Option") to sublease the Center in accordance with the terms and conditions of a definitive sublease agreement ("Sublease") to be entered into, which Sublease shall contain provisions substantially similar to those set forth on Exhibit A and such other terms and conditions as are customary in transactions of this nature and agreed to by the Parties.
- 2. <u>TERM OF OPTION</u>. The term of this Option Agreement shall commence on the Effective Date, and shall continue for one hundred eighty days (180) days ("Option Term").

The Option Term may be extended by Endoscopy Subtenant, at its sole option, for an additional period of one hundred eighty (180) days by written notice to Owner and Master Tenant.

- 3. <u>METHOD OF EXERCISING OPTION</u>. In the event Endoscopy Subtenant elects to exercise the Option, Endoscopy Subtenant shall give written notice (the "Option Notice") to Master Tenant and Owner, and the Parties will execute the Sublease.
- 4. <u>TERMINATION</u>. If Endoscopy Subtenant fails to exercise the Option within the Option Term, then this Option Agreement and the rights of Endoscopy Subtenant granted hereunder shall automatically and immediately terminate without notice or any liability whatsoever and the Parties shall have no further rights or obligations hereunder.
- 5. NOTICE. Any notice or communication required or permitted to be given by any provision of this Option Agreement will be in writing and will be deemed to have been given when delivered personally or by telefacsimile (with a confirming copy sent within one (1) business day by any other means described in this Section) to the Party designated to receive such notice, or on the first business day following the day sent by nationally-recognized overnight courier, or the third (3<sup>rd</sup>) business day after the same is sent by certified mail, postage and charges prepaid, directed to the following addressees or to such other or additional addressees as either Party to this Option Agreement might designate by written notice to the other Party:

To Owner:

RTG Dowell Springs, LLC DDC Dowell Springs, LLC

Attn: Gregory P. Gheen, Managing Member

2220 Sutherland Avenue Knoxville, TN 37919

E-mail Address: ggheen@realtytrustgroup.com

To Master Tenant:

Gastrointestinal Associates, P.C.

Attn: Jeff Dew, CEO 801 Weisgarber Road Knoxville, TN 37909

E-mail Address: jfdew@gihealthcare.com

To Endoscopy Subtenant:

The Endoscopy Center of Knoxville, LP

c/o AmSurg Corporation 1A Burton Hills Boulevard Nashville, TN 37215 E-mail Address:

If notices or other communications are required in this Option Agreement to be given within a specified period and the end of such period falls on other than a business day, such period shall be extended to the next business day. As used in this Option Agreement "business day" shall mean any day other than a Saturday, Sunday, or holiday upon which national banks in Knoxville, Tennessee are closed for business.

- 6. <u>AMENDMENTS</u>. This Option Agreement shall not be amended or modified in any way except by an instrument signed by the Parties.
- 7. GOVERNING LAW. This Option Agreement shall be governed by and construed in accordance with the laws of the State of Tennessee without giving force and effect to its conflicts of law provisions. The Parties agree that the subject matter of this Agreement is unique, and that specific performance shall be available to enforce the obligations undertaken under this Option Agreement.

## 8. MISCELLANEOUS.

- (a) Further Acts, etc. The Parties shall at all times hereafter execute any documents and do any further acts that may be necessary or desirable to carry out the purposes or intent of this Option Agreement. This Option Agreement may be executed with counterpart signature pages and in duplicate originals, each of which shall be deemed an original, and all of which together shall constitute a single instrument.
- (b) Prior Agreements Superseded. This Option Agreement constitutes the Parties' sole and entire agreement and supersedes any prior understandings or written or oral agreements between the Parties with respect to the subject matter hereof which are of no further force or effect. The Exhibits referred herein are integral parts hereof and are made a part of this Option Agreement by reference. The recitals at the beginning of this Option Agreement are hereby incorporated herein and expressly made a part of this Option Agreement.

IN WITNESS WHEREOF, the Parties have executed this Option Agreement as of the Effective Date.

[Signature page follows]

OWNER: RTG DOWELL SPRINGS, LLC  By: Title: Manas, is Messe
Date: 8/14,5
DDC DOWELL SPRINGS, LLC  By:
MASTER TENANT: GASTROINTESTINAL ASSOCIATES, P.C.  By:  Title: Chief Exceptive Office Chief
Date: 8/17/15  ENDOSCOPY SUBTENANT: THE ENDOSCOPY CENTER OF KNOXVILLE, LP
By: Claus And Title: Secretary  Date: 8/13/15

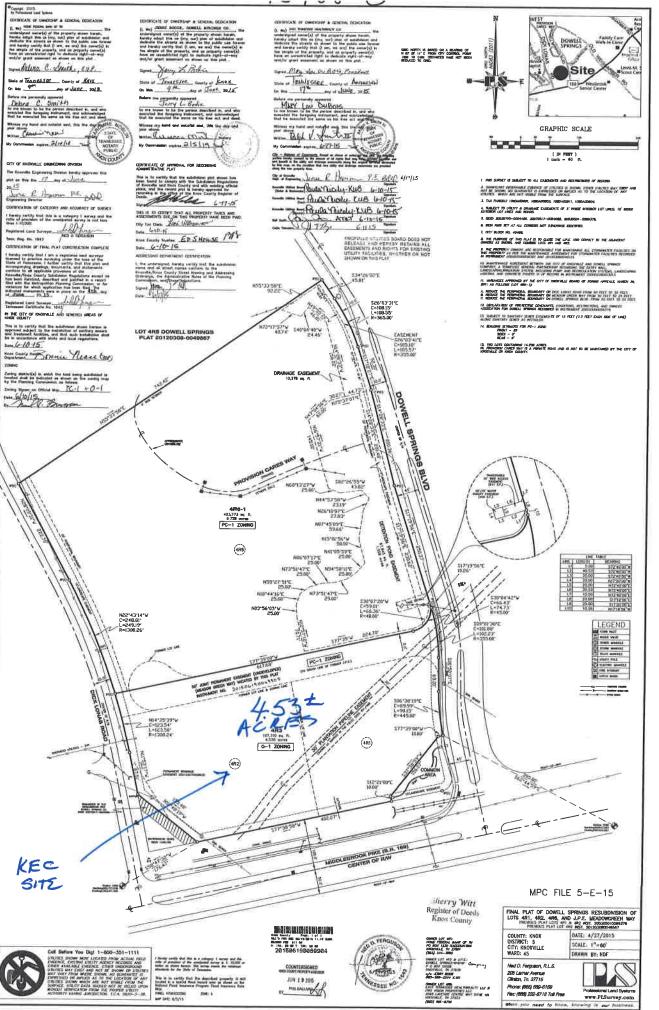
#### Exhibit A

## Sublease Terms

- 1. Term: 15 years from completion of Center shell, with Endoscopy Subtenant having two (2) consecutive five-year renewal options.
- Center/Subleased Premises: Approximately 16,732 usable SF / 17,173 rentable SF, comprising the entire second floor of the Building. The Center will be delivered as shell space and Endoscopy Subtenant will be responsible for build out of the Center, subject to Master Tenant and Owner approvals.
- 3. Rent: \$25.00 per rentable square foot, increased by 1% each year, triple net, plus pro rata allocation of Project Common Area expenses. Notwithstanding the annual 1% escalation of Base Rent, the Base Rent shall be adjusted within 90 days prior to the expiration of the eighth (8th) Lease Year to reflect the then current Fair Market Value of similar spaces, similarly situated in the market area of the Center. The FMV adjustment will be determined by two FMV opinions, one obtained by Master Tenant and the second obtained by Endoscopy Subtenant. Said opinions to be performed by duly qualified and licensed real estate professionals experienced in the valuation and appraisal of similar healthcare facilities in the market area of the Center. Upon request, those opinions will be in writing and will include a listing of comparable properties and other factors included in the valuation. If the findings of the two opinions are within 10% of each other, the two opinions shall be averaged, with the resulting average being the new Base Rent rate. If the two opinions vary by more than 10%, the parties shall jointly engage a third independent qualified real estate professional and the opinion of such third professional shall be the new Base Rent rate. Based on the final opinion derived from the process above, the new Base Rent shall become effective at the commencement of the ninth (9th) Lease Year and the 1% annual increase shall then be applied to the newly determined Base Rent throughout the initial term of the Sublease. Master Tenant and Endoscopy Subtenant agree and acknowledge that all rent and other payments made by Endoscopy Subtenant to Master Tenant shall not exceed the rent and other payments made directly by Master Tenant to Owner with respect to the Center premises.
- 4. Center Sublease will be conditional upon Endoscopy Subtenant obtaining a Certificate of Need ("CON") for the Center.

**B.II.A.--Square Footage and Costs Per Square Footage Chart** 



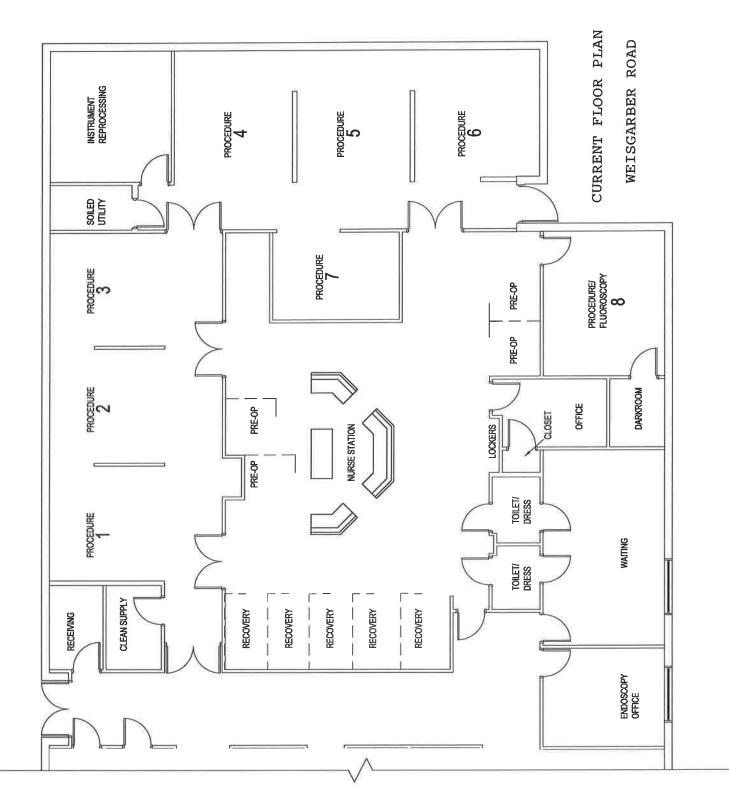


**B.IV.--Floor Plan** 

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14075CON	PROJECT#:

## THE ENDOSCOPY CENTER 801 WEISGARBER ROAD KNOXVILLE, TN 37909

# Design Innovation ARCHITECTS + INTERIORS + PLANNING FOR 5. Gay Street, Suits 201, Knoxville, TN 37802 www.dls-arch.com



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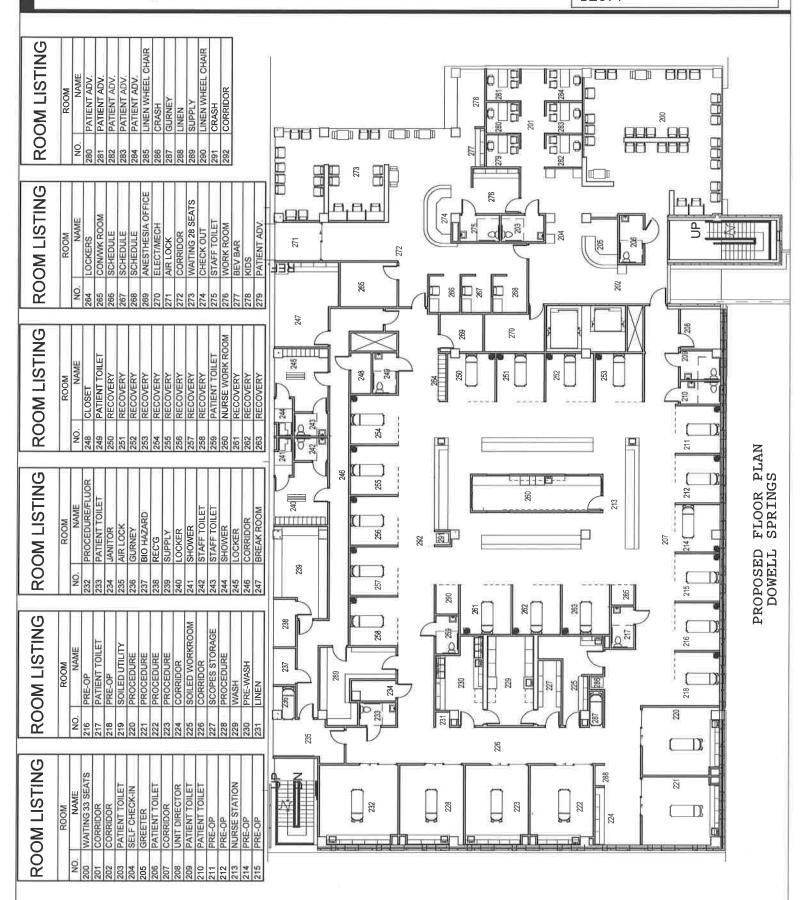
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# DOMELL SPRINGS A NEW FACILITY FOR:

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PRCHITECTS + INTERIORS + PLANUING
402 S. Gay Street, Suite 201, Knoxville, TN 37902
ph 865.677,8546 of 865.291.2221 ks 865.644.3840
www.die-arch.com



## C, Need--1.A Documentation of Project-Specific Criteria

Anesthesia Associates of Knoxville, LLC 801 N. Weisgarber Road Knoxville, TN 37909

## To Whom It May Concern:

Anesthesia Associates of Knoxville, LLC (AAK), currently holds individual contracts with ten (10) Certified Registered Nurse Anesthetists. Additionally, Anesthesia Associates of Knoxville, LLC is under contract with The Endoscopy Center Knoxville, The Knoxville Endoscopy Center – West, and The Endoscopy Center North to provide anesthesia service utilizing one of the ten contracted providers each day of operation, for each room in operation. Anesthesia Associates of Knoxville, LLC is operating under full intent to continue provision of services to the above referenced ASTCs and will remain contracted with relevant US and Tennessee-based government payers including TennCare, Medicare, Medicaid, as well as others.

If additional information is needed, please contact Jeff Dew, Chief Executive Officer, Gastrointestinal Associates (single member owner of Anesthesia Associates of Knoxville, LLC), at <a href="mailto:idea@gihealthcare.com">ifdew@gihealthcare.com</a> or (865) 558-0644.

Sincerely,

Jeff Dew

Chief Executive Officer

Gastrointestinal Associates, P.C.



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Payment

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C, Need--1.A.3.e. Letters of Intent & Qualifications



BERGEIN F. OVERHOLT, MD. MACP, MACG, FASGE

BARRY V. MAVES, MD. FACG

SARKIS J. CHOBANIAN, MD. FACP, MACG

CHARLES M. O'CONNOR, MD.

MEADE C. EDMUNDS, MD,

JOHN M. HAYDEK, MD, FACP, FACG, AGAF, FASGE MARIA B. NEWMAN, MD.

**DIPLOMAT ABIM** RAJ I. NARAYANI, MD,

FACG, FASGE

STEVEN J. BINDRIM, MD. DIPLOMAT ABIM

SCOTT L WILHOITE, MD JOHNNY ALTAWIL, MD

J. MATTHEW MOORE, MD

JEFF DEW, CPA CEO

August 11, 2015

Kimberly Walsh

Division Vice President - Operations

AmSurg Corporation

1A Burton Hills Boulevard Nashville, Tennessee 37215

Dear Ms. Walsh:

Physician

Matthew Moore, M.D.

We, the undersigned, are gastroenterologist who perform endoscopic surgeries in the Knoxville area.

This letter is to support the proposed relocation of The Endoscopy Center, where we have surgical privileges.

That facility's current utilization is very high relative to its restricted operating hours. There is insufficient room for us to perform the surgeries there that we would like to perform.

However, in 2017, when it has relocated with Certificate of Need Approval to the new building at Dowell Springs, with normal daily operating hours, we anticipate performing the following annual number of cases there. These are currently being done in other area facilities, as indicated.

MAIN OFFICE

801 WEISGARBER ROAD, #100 KNOXVILLE, TN 37909 P.O. BOX 59002 KNOXVILLE, TN 37950-9002

> 865.588.5121 FAX 865.588.2126 PLEASE VISIT US AT: www.gihealthcare.com

> NORTH OFFICE 629 DELOZIER WAY

P.O. BOX 59002 KNOXVILLE, TN 37950-9002

865,588,5121 FAX 865.588.2126

WEST OFFICE 11440 PARKSIDE DRIVE P.O. BOX 59002 KNOXVILLE, TN 37950-9002

865.588.5121 FAX 865.588.2126 Cases

440

1,760

600

Where Now Performed

Methodist Medical Center, Oak Ridge The Endoscopy Center of Oak Ridge

The Endoscopy Center North The Endoscopy Center West





<u>Home</u>

Search results for Name BERGEIN F OVERHOLT

### Search results for Name BERGEIN F OVERHOLT

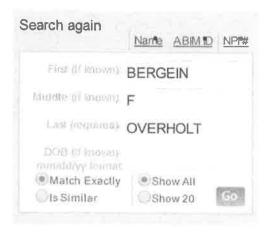
June 30, 2015

### Overholt, Bergein F.

Gastroenterology: Certified Internal Medicine: Certified

Participating in Maintenance of Certification: No

INITIAL CERTIFICATION Internal Medicine: 1968 Gastroenterology: 1970



Check a physician's ABIM Board Certification status by searching name, ABIM ID or NPI# by using the <u>verification tool</u> (at top right).

Important information regarding the physician verification tool:

- Most diplomates certified prior to 1990 are not required to participate in MOC but are strongly encouraged to do so.
- All ABIM certifications issued in 1990 (1987 for critical care medicine and 1988 for geriatric medicine) and thereafter must be maintained through ABIM's MOC program.
- ABIM's website serves as primary source verification.
- Diplomates are publicly reported as participating in MOC for all certifications as long as they are participating in MOC for one certification area.
- Certification status is updated to this system within 5 days of notification to the physicians. Data elements, such as name changes, are updated in ABIM's records within 24 hours of being processed by ABIM.
- If you do not find your physician or they are listed as not certified, they may be certified by another board of the American Board of Medical Specialties. Please check <a href="https://www.certificationmatters.org">www.certificationmatters.org</a>. Additionally, information on Allergy and Immunology, Clinical Laboratory Immunology and Diagnostic Laboratory Immunology diplomates can be now found at <a href="https://www.certificationmatters.org">www.certificationmatters.org</a>.

For more information about ABIM certification and MOC, go to:

MOC Requirements
Annual Reverification Date – April 1st
Reporting Certification Status
Board Eligibility



Home

Search results for Name BARRY V MAVES

### Search results for Name BARRY V MAVES

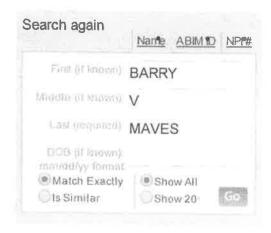
June 30, 2015

### Maves, Barry V.

Gastroenterology: Certified Internal Medicine: Certified

Participating in Maintenance of Certification: Yes

INITIAL CERTIFICATION Internal Medicine: 1983 Gastroenterology: 1985



Check a physician's ABIM Board Certification status by searching name, ABIM ID or NPI# by using the <u>verification tool</u> (at top right).

Important information regarding the physician verification tool:

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- All ABIM certifications issued in 1990 (1987 for critical care medicine and 1988 for geriatric medicine) and thereafter must be maintained through ABIM's MOC program.
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For more information about ABIM certification and MOC, go to:

MOC Requirements
Annual Reverification Date - April 1st
Reporting Certification Status
Board Eligibility



Home | Search results for Name SARKIS J CHOBANIAN

### Search results for Name SARKIS J CHOBANIAN

June 30, 2015

### Chobanian, Sarkis J.

Gastroenterology: Certified Internal Medicine: Certified

Participating in Maintenance of Certification: No

INITIAL CERTIFICATION Internal Medicine: 1981 Gastroenterology: 1985



Check a physician's ABIM Board Certification status by searching name, ABIM ID or NPI# by using the verification tool (at top right).

Important information regarding the physician verification tool:

- Most diplomates certified prior to 1990 are not required to participate in MOC but are strongly encouraged to do so.
- All ABIM certifications issued in 1990 (1987 for critical care medicine and 1988 for geriatric medicine) and thereafter must be maintained through ABIM's MOC program.
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For more information about ABIM certification and MOC, go to:

MOC Requirements

Annual Reverification Date – April 1st
Reporting Certification Status
Board Eligibility

AMERICAN BOARD OF INTERNAL MEDICING

Charles Maurice (D'Connor Fr

HAS MET THE REQUIREMENTS OF THIS BOARD AND IS HEREBY DESIGNATED A DIPLOMATE CERTIFIED IN GASTROENTEROLOGY THE SUBSPECIALTY OF



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Home | Search results for Name MEADE C EDMUNDS

### Search results for Name MEADE C EDMUNDS

June 30, 2015

### Edmunds, Meade C.

Gastroenterology: Certified

Participating in Maintenance of Certification: Yes

INITIAL CERTIFICATION Internal Medicine: 1992 Gastroenterology: 1995



Check a physician's ABIM Board Certification status by searching name, ABIM ID or NPI# by using the <u>verification tool</u> (at top right).

Important information regarding the physician verification tool:

- Most diplomates certified prior to 1990 are not required to participate in MOC but are strongly encouraged to do so.
- All ABIM certifications issued in 1990 (1987 for critical care medicine and 1988 for geriatric medicine) and thereafter must be maintained through ABIM's MOC program.
- ABIM's website serves as primary source verification.
- Diplomates are publicly reported as participating in MOC for all certifications as long as they are participating in MOC for one certification area.
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  and Diagnostic Laboratory Immunology diplomates can be now found at
  <a href="https://www.certificationmatters.org">www.certificationmatters.org</a>.

For more information about ABIM certification and MOC, go to:

MOC Requirements

Annual Reverification Date – April 1st
Reporting Certification Status
Board Eligibility
Representation of Certification Status



Home | Search results for Name JOHN M HAYDEK

### Search results for Name JOHN M HAYDEK

June 30, 2015

### Haydek, John M.

Gastroenterology: Certified Internal Medicine: Certified

Participating in Maintenance of Certification: Yes

INITIAL CERTIFICATION Internal Medicine: 1991 Gastroenterology: 1993



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# AMERICAN BOARD OF INTERNAL MEI

# Maria del Mar Comet Rewman

HAS MET THE REQUIREMENTS OF THIS BOARD AND IS HEREBY CERTIFIED FOR THE PERIOD 2001 THROUGH 2011 AS A DIPLOMATE IN

GASTROENTEROLOGY



CHAIR

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SUBSPECIALTY ROARD ON GASTROENTEROLOGY

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NUMBER 179818

2001



<u>Home</u>

Search results for Name RAJ I NARAYANI

### Search results for Name RAJ I NARAYANI

June 30, 2015

### Narayani, Raj I.

Gastroenterology: Certified Internal Medicine: Certified

Participating in Maintenance of Certification: Yes

INITIAL CERTIFICATION Internal Medicine: 1998 Gastroenterology: 2001



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Reporting Certification Status
Board Eligibility



Home | Search results for Name STEVEN J BINDRIM

### Search results for Name STEVEN J BINDRIM

June 30, 2015

### Bindrim, Steven J.

Gastroenterology: Certified

Participating in Maintenance of Certification: Yes

INITIAL CERTIFICATION Internal Medicine: 1991 Gastroenterology: 1995



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Home

Search results for Name SCOTT L WILHOITE

### Search results for Name SCOTT L WILHOITE

June 30, 2015

### Wilhoite, Scott L.

Gastroenterology: Certified

Participating in Maintenance of Certification: Yes

INITIAL CERTIFICATION Internal Medicine: 1990 Gastroenterology: 1993



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Home

Search results for Name JOHNNY ALTAWIL

### Search results for Name JOHNNY ALTAWIL

June 30, 2015

### Altawil, Johnny

Gastroenterology: Certified Internal Medicine: Certified

Participating in Maintenance of Certification: Yes

INITIAL CERTIFICATION Internal Medicine: 2010 Gastroenterology: 2013



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Annual Reverification Date – April 1st
Reporting Certification Status
Board Eligibility



Home | Search results for Name JOHN MATTHEW MOORE

### Search results for Name JOHN MATTHEW MOORE

June 30, 2015

### Moore, John M.

Gastroenterology: Certified Internal Medicine: Certified

Participating in Maintenance of Certification: Yes

INITIAL CERTIFICATION Internal Medicine: 2011 Gastroenterology: 2014



Check a physician's ABIM Board Certification status by searching name, ABIM ID or NPI# by using the <u>verification tool</u> (at top right).

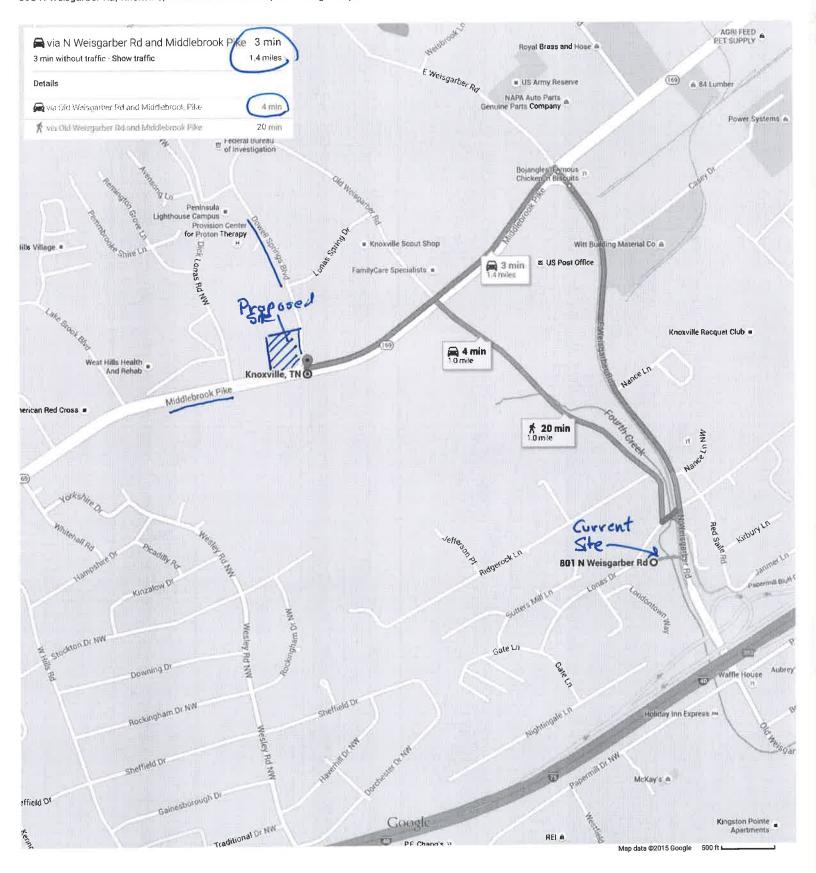
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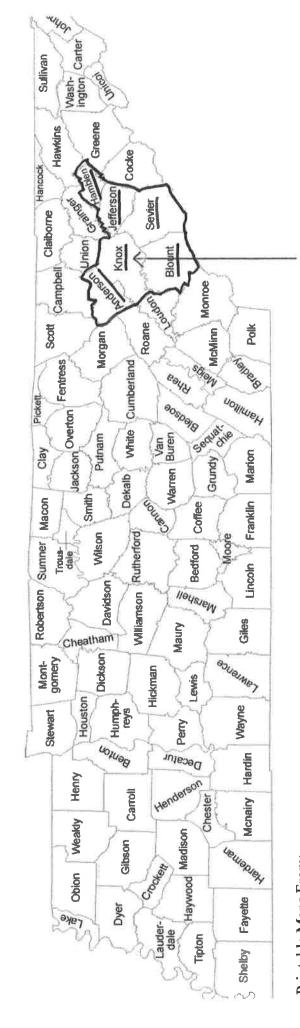
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Reporting Certification Status
Board Eligibility

C, Need--3 Service Area Maps



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Printable Maps From: terproof Paper.com

PRIMARY SERVICE AREA

THE ENDOSCOPY CENTER



# C, Economic Feasibility--1 Documentation of Construction Cost Estimate



August 6, 2015

Ms. Melanie Hill
Executive Director
State of Tennessee
Health Services and Development Agency
500 Deadrick Street, Suite 850
Nashville, TN 37243

Re:

The Endoscopy Center @ Dowell Springs - Knoxville, TN:

Endoscopy Center Relocation - Verification of Estimated Construction Cost

DIA Project Number: 14075

File: F01 103

Dear Ms. Hill:

We have reviewed the construction cost developed for the endoscopy center relocation project for The Endoscopy Center to the Dowell Springs site in Knoxville, TN. The construction cost of \$4,300,124.00 is for build-out of the interior space.

It is our professional opinion that the construction cost proposed is very adequate and consistent with historical data based on similar type projects. It is important to note, that our opinion is based on normal market conditions, price escalation, etc.

The project will be developed under the current codes and standards enforced by the State of Tennessee and the City of Knoxville as follows:

### STATE OF TENNESSEE

2006 INTERNATIONAL BUILDING CODE

2006 INTERNATIONAL PLUMBING CODE

2006 INTERNATIONAL MECHANICAL CODE

2006 INTERNATIONAL GAS CODE

2006 NFPA 1, EXCLUDING NFPA 5000

2006 NFPA 101 LIFE SAFETY CODE

2005 NATIONAL ELECTRIC CODE

2002 NORTH CAROLINA ACCESSIBILITY CODE WITH 2004 AMENDMENTS

2010 AMERICANS WITH DISABILITIES ACT (ADA)

2010 AIA GUIDELINES FOR DESIGN AND CONSTRUCTION OF HEALTH CARE FACILITIES (FGI)

2007 ASHRAE HANDBOOK OF FUNDAMENTALS

### CITY OF KNOXVILLE

2012 INTERNATIONAL BUILDING CODE

2012 INTERNATIONAL PLUMBING CODE

2012 INTERNATIONAL FIRE CODE W/ LOCAL AMENDMENTS

2012 INTERNATIONAL MECHANICAL CODE

2012 INTERNATIONAL GAS CODE

2011 NATIONAL ELECTRIC CODE

2012 NFPA 101 LIFE SAFETY CODE

2010 AIA GUIDELINES FOR DESIGN AND CONSTRUCTION OF HEALTH CARE FACILITIES (FGI)

2009 ICC/AMERICAN NATIONAL STANDARD (ANSI) A117.1

2010 AMERICANS WITH DISABILITIES ACT (ADA)

2012 INTERNATIONAL ENERGY CONSERVATION CODE (IECC)

402 S. Gay Street, Suite 201, Knoxville, TN 37902 ph 865.637.8540 or 865.291.2221 fx 865.544.3840 www.dia-arch.com

Sincerely, Design Innovation

Richard Norris, AlA

Senior Project Architect [TN License No. 00016433]

ec: Faris Eid; Greg Campbell; Brandy Williams, Design Innovation

# C, Economic Feasibility--2 Documentation of Availability of Funding

### <u>AMSURG</u>

1A Burton Hills Boulevard Nashville, Tennessee 37215

PHONE 615.665.1283 TOLL FREE 800.945.2301 FAX 615.665.0755

www.amsurg.com

August 10, 2015

Melanie M. Hill, Executive Director Tennessee Health Families Commission Andrew Jackson State Office Building, Ninth Floor 500 Deaderick Street Nashville, TN 37243

Dear Mrs. Hill:

The Endoscopy Center of Knoxville, L.P., is an existing single-specialty ASTC limited to endoscopy. AmSurg indirectly owns 51% of that limited partnership.

The facility is filing a Certificate of Need application to move to a new location in Knoxville. The actual capital cost of the project is estimated at approximately \$6,883.000.

As Chief Financial Officer of AmSurg, I am writing to confirm that AmSurg Corp. will provide all of the required funding for the project in the form of a loan to the applicant LLC. The Certificate of Need application includes the company's financial statements documenting that sufficient cash reserves, operating income, and lines of credit exist to provide that funding.

Sincerely,

Claire Glumi

Chief Financial Officer and Executive Vice President

C, Economic Feasibility--10 Financial Statements

### 2001 Knoxville GI

### Balance Sheets March 31, 2015

	Mar 2015	Feb 2015	Increase (Decrease)	Dec 2014	Increase (Decrease)
ASSETS	<del></del>				
Current assets:					
Cash and cash equivalents Accounts receivable:	411,667	406,634	5,033	533,662	(121,996)
Accounts receivable. Accounts receivable gross	2,011,151	1,766,830	244,321	2,298,483	(287,332)
Contractual allowance	(1,143,016)	(995,020)	(147,996)	(1,386,043)	243,027
Bad debt allowance	(120,482)	(112,668)	(7,814)	(92,751)	(27,731)
Accounts receivable, net	747,653	659,142	88,510	819,689	(72,036)
Other receivables	45,885	30,382	15,503	39,039	6,846
Supplies inventory Prepaid and other current assets	100,604 24,785	100,604 24,043	0 742	100,604 43,482	0 (18,697)
Total current assets	1,330,593	1,220,805	109,788	1,536,475	(205,882)
Total current accord	1,000,000	1,220,000	100,700	1,000,470	(200,002)
Property and equipment: Building improvements	1,244,784	1,244,784	0	1,244,784	0
Equipment	3,601,973	3,585,246	16,726	3,585,246	16,726
	4,846,756	4,830,030	16,726	4,830,030	16,726
Accumulated depreciation	(4,033,292)	(4,008,963)	(24,328)	(3,968,186)	(65,106)
Property and equipment, net	813,465	821,067	(7,602)	861,844	(48,379)
Intangible assets:					
Goodwill, net	4,199,118	4,199,118	0	4,199,118	0
Other intangibles	47,997	49,357	(1,361)	52,078	(4,082)
Intangible assets, net	4,247,114	4,248,475	(1,361)	4,251,196	(4,082)
Total assets	6,391,172	6,290,346	100,826	6,649,515	(258,343)
LIABILITIES AND EQUITY					
Current liabilities:					
Accounts payable	228,833	255,159	(26,326)	284,134	(55,300)
Current income taxes payable Accrued salaries and benefits	36,725	22,376	14,348 43,104	9,901	26,824 48,854
Other accrued liabilities	253,381 12,399	210,276 8,729	43,104 3,670	204,526 0	48,854 12,399
Intercompany payable (receivable)	4,969	6,848	(1,878)	4,279	690
	536,306	503,388	32,919	502,839	33,467
Other long-term liabilities	165,261	165,350	(88)	165,526	(264)
Equity:					
GP capital account	2,901,698	2,867,021	34,678	3,050,387	(148,688)
LP capital account	2,787,906	2,754,588	33,318	2,930,763	(142,858)
Total equity	5,689,604	5,621,609	67,995	5,981,150	(291,546)
Total liabilities and equity	6,391,172	6,290,346	100,826	6,649,515	(258,343)

E02 IS Centers
Data as of APR 10, 2015 at 5:20 p.m.

### 2001-001 Knoxville GI

## Statement of Earnings For the Period Ending March 31, 2015

	Monthly Actual	Monthly Budget	Prior Month	YTD Actual	YTD Budget	YTD Prior Year
Gross charges:					,	·
Gl revenue	1,557,928	1,396,629	1,141,633	4,167,666	3,886,272	4,036,617
Total gross charges	1,557,928	1,396,629	1,141,633	4,167,666	3,886,272	4,036,617
Estimated reserves:						
Contractual adjustments	1,071,897	961,368	805,993	2,914,691	2,675,111	2,741,485
Bad debt expense	10,905	18,156	7,991	29,174	50,521	98,256
Total estimated adjustments	1,082,802	979,524	813,984	2,943,865	2,725,632	2,839,742
Net revenue	475,125	417,105	327,649	1,223,801	1,160,640	1,196,875
Operating expenses:						
Salaries and benefits	217,032	209,456	187,417	589,782	628,369	686,327
Medical supplies and drugs	44,254	34,535	40,965	122,713	96,097	95,036
Other variable expenses	53,336	64,020	68,111	168,887	190,246	219,533
Fixed expenses	21,010	21,803	21,262	63,654	65,409	63,688
Operating taxes	3,003	3,272	3,049	9,070	9,816	10,042
Depreciation	16,626	16,579	16,738	50,445	50,279	58,527
Total operating expenses	355,261	349,665	337,541	1,004,551	1,040,216	1,133,153
Operating income	119,864	67,440	(9,892)	219,250	120,424	63,723
Other income and (expense):						
Interest expense, net	37	41	0	41	123	(1,065)
Fees and other	471	339	913	1,707	1,017	594
Earnings before income taxes	120,372	67,820	(8,979)	220,999	121,564	63,252
Income tax expense	14,348	10,023	662	26,824	25,171	18,398
Net earnings	106,024	57,797	(9,640)	194,174	96,393	44,854

### 2001 Knoxville Gl

### Balance Sheets December 31, 2014

	Dec 2014	Nov 2014	Increase (Decrease)	Dec 2013	Increase (Decrease)
ASSETS					
Current assets:  Cash and cash equivalents  Accounts receivable:	533,662	485,924	47,739	310,859	222,804
Accounts receivable.  Accounts receivable gross  Contractual allowance  Bad debt allowance	2,298,483 (1,386,043) (92,751)	1,981,154 (1,138,568) <u>(66,844)</u>	317,329 (247,475) (25,907)	2,031,102 (1,063,546) (143,767)	267,381 (322,497) 51,016
Accounts receivable, net	819,689	775,741	43,948	823,789	(4,100)
Other receivables Supplies inventory Prepaid and other current assets	39,039 100,604 43,482	22,947 109,632 40,586	16,091 (9,028) 	22,963 109,632 40,946	16,075 (9,028) 2,536
Total current assets	1,536,475	1,434,830	101,645	1,308,188	228,287
Property and equipment: Building improvements Equipment	1,244,784 3,585,246	1,244,784 3,563,580	0 21,666	1,244,784 3,512,734	0 72,512
Accumulated depreciation	4,830,030 (3,968,186)	4,808,364 (3,945,312)	21,666 (22,873)	4,757,518 (3,695,632)	72,512 (272,553)
Property and equipment, net	861,844	863,051	(1,207)	1,061,885	(200,041)
Intangible assets: Goodwill, net Other intangibles	4,199,118 52,078	4,199,118 45,249	0 6,829	4,199,118 59,862	0 (7,783)
Intangible assets, net	4,251,196	4,244,367	6,829	4,258,979	(7,783)
Total assets	6,649,515	6,542,248	107,267	6,629,052	20,463
LIABILITIES AND EQUITY					
Current liabilities:     Accounts payable     Current income taxes payable     Accrued salaries and benefits     Other accrued liabilities     Intercompany payable (receivable)	284,134 9,901 204,526 0 4,279	285,870 27,185 165,914 1,624 7,391	(1,736) (17,285) 38,612 (1,624) (3,112)	236,263 2,749 226,494 0 5,398	47,871 7,152 (21,968) 0 (1,119)
intercompany payable (recorraise)	502,839	487,985	14,854	470,904	31,936
Long-term debt Other long-term liabilities	0 165,526	0 165,614	0 (88)	149,556 162,942	(149,556) 2,584
Equity: GP capital account LP capital account	3,050,387 2,930,763	3,003,212 2,885,438	47,175 45,325	2,981,282 2,864,369	69,105 66,395
Total equity	5,981,150	5,888,650	92,501	5,845,651	135,500
Total liabilities and equity	6,649,515	6,542,248	107,267	6,629,052	20,463

E02 IS Centers
Data as of MAY 26, 2015 at 8:36 a.m.

### 2001-001 Knoxville Gl

# Statement of Earnings For the Period Ending December 31, 2014

	Monthly Actual	Monthly Budget	Prior Month	YTD Actual	YTD Budget	YTD Prior Year
Gross charges:						
GI revenue	1,800,484	1,454,002	1,397,248	17,454,957	17,136,013	20,400,296
Total gross charges	1,800,484	1,454,002	1,397,248	17,454,957	17,136,013	20,400,296
Estimated reserves:						
Contractual adjustments	1,243,137	1,002,480	983,485	12,064,650	11,809,853	14,100,654
Bad debt expense	12,603	11,632	9,781	217,185	137,089	192,802
Total estimated adjustments	1,255,740	1,014,112	993,266	12,281,835	11,946,942	14,293,456
Net revenue	544,744	439,890	403,983	5,173,122	5,189,071	6,106,840
Ou anting augustin						
Operating expenses:	221,587	241,351	175,401	2,407,309	2,896,212	2,878,240
Salaries and benefits	49,156	41,359	37,318	480,012	487,432	581,418
Medical supplies and drugs		41,359 65,850	52,545	731,500	853,200	836,271
Other variable expenses	61,306	-	20,052	250,278	274,623	261,947
Fixed expenses	22,248	22,928	1,430	36,022	38,640	39,701
Operating taxes	2,023	3,220	19,172	231,163	227,312	238,173
Depreciation	19,891	18,671			-	4,835,750
Total operating expenses	376,211	393,379	305,919	4,136,283	4,777,419	
Operating income	168,533	46,511	98,064	1,036,839	411,652	1,271,091
Other income and (expense):						
Interest expense, net	68	7	0	(1,867)	(2,230)	(8,082)
Fees and other	323	279	94	4,378	3,348	5,304
Earnings before income taxes	168,924	46,797	98,159	1,039,349	412,770	1,268,312
Income tax expense	18,214	11,875	14,420	138,342	97,859	146,418
Net earnings	150,710	34,922	83,738	901,007	314,911	1,121,894

	2			
			9	



### Management's Discussion and Analysis of Financial Condition and Results of Operations - (continued)

### Ambulatory Services Operations

The following table presents the number of procedures performed at our continuing centers and changes in the number of ASCs in operation, under development and under letter of intent for the years ended December 31, 2014, 2013 and 2012. An ASC is deemed to be under development when a LP or LLC has been formed with the physician partners to develop the ASC.

2014	2013	2012
1,645,350	1,609,761	1,478,888
237	233	229
9	3	2
233	230	216
10	6	18
6	3	4
2		_
5	5	2
	1,645,350 237 9 233 10	1,645,350 1,609,761 237 233 9 3 233 230 10 6

Of the continuing centers in operation at December 31, 2014, 150 centers performed gastrointestinal endoscopy procedures, 51 centers performed procedures in multiple specialties, 37 centers performed ophthalmology procedures and 8 centers performed orthopaedic procedures.

A significant measurement of how much our ambulatory services revenues grow from year to year for existing centers is our ambulatory services same-center revenue percentage. We define our same-center group each year as those centers that contain full year-to-date operations in both comparable reporting periods, including the expansion of the number of operating centers associated with a LP or LLC. Ambulatory services revenues at our 2014 same-center group, comprising 224 centers and constituting approximately 91% of our total number of consolidated centers, increased by 0.7% during the year ended December 31, 2014 compared to the prior period.

The following table presents selected statement of earnings data expressed in dollars (in thousands) and as a percentage of net revenue for our ambulatory services segment.

		For t	he Year Ended	December 31,		
	2014		2013		2012	
Net revenue	\$ 1,109,935	100.0% \$	1,057,196	100.0% \$	899,245	100.0%
Operating expenses:						
Salaries and benefits	341,906	30.8	327,585	31.0	284,528	31.6
Supply cost	163,004	14.7	153,126	14.5	126,919	14.1
Other operating expenses	230,307	20.7	216,501	20.5	185,866	20.7
Transaction costs	29,004	2.6	300		700	0.1
Depreciation and amortization	34,667	3.1	32,400	3.1	29,255	3.3
Total operating expenses	798,888	72.0	729,912	69.0	627,268	69.8
Gain on deconsolidation	3,411	0.3	2,237	0.2	_	
Equity in earnings of unconsolidated affiliates	3,199	0.3	3,151	0.3	1,564	0.2
Operating income	\$ 317,657	28.6% \$	332,672	31.5% \$	273,541	30.4%

### Financial Statements and Supplementary Data - (continued)

### AmSurg Corp. Consolidated Balance Sheets (In thousands)

	D —	ecember 31, 2014	_	December 31, 2013
Assets				
Current assets:				
Cash and cash equivalents	\$	208,079	\$	50,840
Restricted cash and marketable securities		10,219		_
Accounts receivable, net of allowance of \$113,357 and \$27,862, respectively		233,053		105,072
Supplies inventory		19,974		18,414
Prepaid and other current assets		115,362	_	36,699
Total current assets		586,687		211,025
Property and equipment, net		180,448		163,690
Investments in unconsolidated affiliates		75,475		15,526
Goodwill		3,381,149		1,758,970
Intangible assets, net		1,273,879		27,867
Other assets	_	25,886	_	866
Total assets	\$	5,523,524	\$	2,177,944
Liabilities and Equity				
Current liabilities:				
Current portion of long-term debt	\$	18,826	\$	20,844
Accounts payable		29,585		27,501
Accrued salaries and benefits		140,044		32,294
Accrued interest		29,644		1,885
Other accrued liabilities		67,986		7,346
Total current liabilities		286,085		89,870
Long-term debt		2,232,186		583,298
Deferred income taxes		633,480		176,020
Other long-term liabilities		89,443		25,503
Commitments and contingencies				
Noncontrolling interests – redeemable		184,099		177,697
Equity:				
Mandatory convertible preferred stock, no par value, 5,000 shares authorized, 1,725 and 0 shares issued and outstanding, respectively		166,632		-
Common stock, no par value, 70,000 shares authorized, 48,113 and 32,353 shares outstanding, respectively		885,393		185,873
Retained earnings		627,522		578,324
Total AmSurg Corp. equity		1,679,547		764,197
Noncontrolling interests – non-redeemable		418,684	_	361,359
Total equity		2,098,231	7	1,125,556
Total liabilities and equity	\$	5,523,524	\$	2,177,944

### Financial Statements and Supplementary Data - (continued)

### AmSurg Corp. Consolidated Statements of Earnings (In thousands, except earnings per share)

	Year Ended December 31,					
	-	2014	20	13		2012
Revenues	\$	1,738,950	\$ 1	,057,196	\$	899,245
Provision for uncollectibles		(117,001)		_=		
Net revenues		1,621,949	1	,057,196		899,245
Operating expenses:						
Salaries and benefits		694,576		327,585		284,528
Supply cost		164,296		153,126		126,919
Other operating expenses		284,928		216,501		185,866
Transaction costs		33,890		300		700
Depreciation and amortization		60,344		32,400		29,255
Total operating expenses		1,238,034		729,912		627,268
Gain on deconsolidation		3,411		2,237		
Equity in earnings of unconsolidated affiliates		7,038		3,151		1,564
Operating income	V <del>==</del> ==	394,364		332,672		273,541
Interest expense, net		83,285		29,525		16,950
Debt extinguishment costs		16,887				<del>5</del>
Earnings from continuing operations before income taxes		294,192		303,147		256,591
Income tax expense		48,103		48,654		40,893
Net earnings from continuing operations		246,089		254,493		215,698
Net earnings (loss) from discontinued operations		(1,296)		7,051		7,945
Net earnings		244,793		261,544		223,643
Less net earnings attributable to noncontrolling interests		191,092		188,841		161,080
Net earnings attributable to AmSurg Corp. shareholders		53,701		72,703		62,563
Preferred stock dividends		(4,503)				
Net earnings attributable to AmSurg Corp. common shareholders	\$	49,198	\$	72,703	\$	62,563
Amounts attributable to AmSurg Corp. common shareholders:						
Earnings from continuing operations, net of income tax	\$	50,777	\$	71,009	\$	60,037
Earnings (loss) from discontinued operations, net of income tax	2	(1,579)		1,694		2,526
Net earnings attributable to AmSurg Corp. common shareholders	\$	49,198	\$	72,703	\$	62,563
Basic earnings per share attributable to AmSurg Corp. common shareholders:						
Net earnings from continuing operations	\$	1.29	\$	2.27	\$	1.95
Net earnings (loss) from discontinued operations		(0.04)		0.05		0.08
Net earnings	\$	1.25	\$	2.32	\$	2.03
Diluted earnings per share attributable to AmSurg Corp. common shareholders:	-					
Net earnings from continuing operations	\$	1.28	\$	2,22	\$	1.90
Net earnings (loss) from discontinued operations	7	(0.04)		0.05		0.08
Net earnings	\$	1.24	\$	2.28	\$	1,98
Weighted average number of shares and share equivalents outstanding:						
Basic		39,311		31,338		30,773
Diluted		39,625		31,954		31,608

### AmSurg Corp. Consolidated Statements of Changes in Equity (In thousands)

		AmSurg	Corp. Sl	nareholders				Noncontrolling
	-		Man	datory		Noncontrolling		Interests –
	Comm	on Stock		ertible ed Stock	Retained	Interests – Non-	Total Equity	Redeemable (Temporary
	Shares	Amount	Shares	Amount	Earnings	Redeemable	(Permanent)	Equity)
Balance at January 1, 2012	31,284	\$ 173,187	_	\$ —	\$ 443,058	-		\$ 170,636
Net earnings	-		==:	_	62,563	26,303	88,866	134,777
Issuance of restricted stock	281	_	500		-		_	-
Cancellation of restricted stock	(2)	_	=			_	452	-
Stock options exercised	842	18,214	-	-	=	( <del></del> )	18,214	-
Stock repurchased	(464)	(13,101)		-	-	-	(13,101)	
Share-based compensation		6,692	-	-	=	_	6,692	==:
Tax benefit related to exercise of stock	-	1,834	-	-	-	-	1,834	
Distributions to noncontrolling interests, net of capital contributions			-	_	-	(26,514)	(26,514)	(136,356)
Acquisitions and other transactions impacting noncontrolling interests		252	-	-	-	174,615	174,867	6,957
Disposals and other transactions impacting noncontrolling interests		(3,211)	_	:==		4,352	1,141	(632)
Balance at December 31, 2012	31,941	\$183,867		\$ —	\$ 505,621	\$ 310,978	\$ 1,000,466	\$ 175,382
Net earnings	-	===	-	_	72,703	49,789	122,492	139,052
Issuance of restricted stock	292		-	900	_			-
Cancellation of restricted stock	(16)	<del></del>	-	1==1	_			_
Stock options exercised	1,393	33,349	_	-	_	·=-	33,349	_
Stock repurchased	(1,257)	(45,964)	-	-	-	=	(45,964)	<del>1 - 1</del>
Share-based compensation	100	8,321	-	-	_	-	8,321	_
Tax benefit related to exercise of stock	_	7,247	=	-		-	7,247	===
Distributions to noncontrolling interests, net of capital contributions	-	-	-	-	_	(49,533)	(49,533)	(134,298)
Acquisitions and other transactions impacting noncontrolling interests	_	679	-	-	-	48,115	48,794	(319)
Disposals and other transactions impacting noncontrolling interests	7	(1,626)		-	·—	2,010	384	(2,120)
Balance at December 31, 2013	32,353	\$ 185,873	-	\$ —	\$ 578,324			\$ 177,697
Net earnings		=	-	_	53,701	56,048	109,749	135,044
Issuance of stock	15,490	693,289	1,725	166,632	.=	_	859,921	-
Issuance of restricted stock	272	===	-		//==			<u></u>
Cancellation of restricted stock	(12)	-	-	; <del>==</del>	9	13-14		=
Stock options exercised	111	2,630	-	7,000		1 <del>-1</del>	2,630	( <del>) = </del> (
Stock repurchased	(101)	(4,615)	-	-	-	-	(4,615)	-
Share-based compensation		10,104	-	-	_	_	10,104	-
Tax benefit related to exercise of stock		3,177	_	-	_	-	3,177	÷ <del></del>
Dividends paid on preferred stock	-	-	-		(4,503)	_	(4,503)	<del></del>
Distributions to noncontrolling interests, net of capital contributions	_	_	=	-	_	(56,439)	(56,439)	(133,594)
Acquisitions and other transactions impacting noncontrolling interests	=	744	=	==	_	54,725	55,469	6,482
Disposals and other transactions impacting noncontrolling interests		(5,809)	_=			2,991	(2,818)	(1,530)
Balance at December 31, 2014	48,113	\$885,393	1,725	\$ 166,632	\$ 627,522	\$ 418,684	\$ 2,098,231	\$ 184,099

C, Orderly Development--7(C)
Licensing & Accreditation Inspections



### STATE OF TENNESSEE DEPARTMENT OF HEALTH

OFFICE OF HEALTH LICENSURE AND REGULATION
EAST TENNESSEE REGION
5904 LYONS VIEW PIKE, BLDG, 1
KNOXVILLE, TENNESSEE 37919

July 09, 2012

Ms. Gale Mahan, RN, Administrator The Endoscopy Center 801 Weisgarber Rd Knoxville TN 37950

RE: 44C0001014

Dear Ms. Mahan:

The East Tennessee Region of Health Care Facilities conducted your annual recertification survey on April 3-4, 2012. An on-site revisit was conducted on May 3 and June 21, 2012. Based on the on-site revisit on May 3 and June 21, 2012 and review of your plan of correction, we are accepting your plan of correction and your facility is in compliance with all participation requirements as of May 19, 2012

If you have any questions, please contact the East Tennessee Regional Office by phone: 865-588-5656 or by fax: 865-594-5789.

Sincerely,

Karen B. Kirby, RN
Regional Administrator

East TN Health Care Facilities

KK: kg

TN000

completed copy to cm 5 4/17/12



### STATE OF TENNESSEE DEPARTMENT OF HEALTH

OFFICE OF HEALTH LICENSURE AND REGULATION
EAST TENNESSEE REGION
5904 LYONS VIEW PIKE, BLDG. 1
KNOXVILLE, TENNESSEE 37919

April 11, 2012

Ms. Gayle Mahan, R.N., Administrator The Endoscopy Center 801 Weisgarber Road, Suite 100 Knoxville, TN 37909

Dear Ms. Mahan:

Enclosed is the Statement of Deficiencies, which was developed as a result of the recertification survey, conducted at your facility on April 4, 2012. You are requested to submit a Credible Allegation of Compliance within ten (10) days after receipt of this letter with acceptable time frames for correction of the cited deficiencies. Corrective action must be achieved no later than May 19, 2012, (45 days from the date of the survey). Please notify this office when these deficiencies are corrected. A revisit must be conducted prior to the forty-fifth day to verify compliance. Once corrective action is confirmed, a favorable recommendation for re-certification will be considered.

The following one (1) condition level deficiency was cited for noncompliance: Q 001 416.25 Basic Requirements

The following standard level deficiencies were cited for noncompliance: Q 002, Q 101, Q 105, Q 181, Q223, Q 242

Based on noncompliance with the aforementioned Condition and Standard Level Deficiencies, this office is recommending to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated if substantial compliance is not achieved. Please be advised that under the disclosure of survey information provisions, the Statement of Deficiencies will be available to the public.

Your plan of correction must contain the following:

- How the deficiency will be corrected;
- > How the facility will prevent the same deficiency from recurring.
- > The date the deficiency will be corrected;
- > How ongoing compliance will be monitored.

Ms. Gayle Mahan, R.N. April 11, 2012 Page 2

If there are any delays in completing your Plan of Correction, please notify this office in writing. After the Plan of Correction has been received by our office and has been reviewed and found to be acceptable, you will not be receiving notice of the acceptance; however, if the Plan of Correction is unacceptable we will be in contact with you. Before the plan can be considered "acceptable," it must be signed and dated by the administrator

Should you have questions or if there is any way this office may be of assistance, please do not hesitate to call our office at 865-588-5656.

Sincerely,

Karen B. Kirby, R.N. Regional Administrator

East TN Health Care Facilities

Karen B. Kin by mad

**KBKcvb** 

Enclosure

PRINTED: 04/05/2012 **FORM APPROVED** OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44C0001014	(X2) MULTIP A BUILDING B WING	LE CONSTRUCTION	(X3) DATE SI COMPLE	
	ROVIDER OR SUPPLIER		80	EET ADDRESS, CITY, STATE, ZIP CO 1 WEISGARBER RD NOXVILLE, TN 37950		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
Q 000 Q 001	February 14 - 15, 2 in compliance with of Coverage, Basic Please Refer to Q0 416.25 BASIC REC Participation as an (a) Meet the det (b) Have in effe	ication survey conducted on 2012 the facility was found not Requirement 416.25 Condition Requirements.  202  201REMENTS  ASC is limited to facilities that-finition in §416.2; and ct an agreement obtained in	Q 000	Q 001 416.26 BASIC REPLANDED THE Endoscopy Center of Correction	will ensure shari	0
Q 002	Based on observate failed to ensure the operated for the exout-patient surgical. The facility was cite Coverage for Basic ensure common spanared during over the Ambulatory Suroffice practice.  The findings include Please refer to Q00 416.2 DEFINITION. As used in this part Ambulatory surgice distinct entity that opurpose of providing not requiring hospit expected duration of 24 hours following as	is not met as evidenced by: tion and interview, the facility Ambulatory Surgery Center clusive purpose of providing I services as a distinct entity. ed for the Condition of Requirements for failing to pace and services were not lapping hours of operation of rgery Center and a physician's ed:  22 S	Q 002	of common spaces will the Physician office is clearly specified by the Physician office will from 6:30AM to 11AM I friday. The Endoscopy Coperational during those Monday through Friday. Center patients will be retaken into the space destendoscopy Center prior office patients. Discharg Center patients will occur for the patients will occur for the patients will occur for the patients. This was one of the patients of the patients will occur for the patients. This was one of the patients will occur for the patients. This was one of the patients will occur for the patients. This was one of the patients will occur for the patients. This was one of the patients will be patients. This was one of the patients will be patients.	be closed daily Monday through Center will be e same hours All Endoscopy ecceived and signated as to the arrival of ing of Endoscop ur through the arge area to of the vill begin on 05-	n V

ny deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 yes following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

PRINTED: 04/05/2012 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PE	ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER: 44C0001014	(X2) MULT A. BUILDII B. WING	TIPLE CONSTRUCTION NG	(X3) DATE S COMPL	ETED
ENDOS	PROVIDER OR SUPPLIER		II.	1	REET ADDRESS, CITY, STATE, ZIP CODE 801 WEISGARBER RD KNOXVILLE, TN 37950		04/2012
PREFIX TAG	(EACH DEFICIENC)	Y MUST (	OF DEFICIENCIES BE PRECEDED BY FULL TIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	YOULD BE	COMPLETION DATE
Q 001	in compliance with of Coverage, Basic Please Refer to Q0 416.25 BASIC REC Participation as an (a) Meet the defi (b) Have in effect accordance with this This CONDITION is Based on observat failed to ensure the operated for the excout-patient surgical The facility was cited Coverage for Basic ensure common spatianed during overlate Ambulatory Surgical The findings include Please refer to Q002 416.2 DEFINITIONS As used in this part: Ambulatory surgical distinct entity that oppurpose of providing not requiring hospital expected duration of	cation 012 the Requirement of th	limited to facilities that- n §416.2; and greement obtained in art.  net as evidenced by: d interview, the facility atory Surgery Center purpose of providing es as a distinct entity. e Condition of ements for failing to d services were not hours of operation of enter and a physician's  or ASC means any exclusively for the all services to nation to	Q 0001		r designee waff are rocess istrator or ty daily for there are no ce is not be modified until 100% one ys is ed any future to the Cented appropriators will be heduled QA	e er te
ORATORY	DIRECTOR'S OR PROVIDE	RISUPPL	IER REPRESENTATIVES SIGNA	TURE	TITLE		XB) DATE

her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days illowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ogram participation.

)RM CMS-2567(02-99) Previous Versions Obsolete

Event ID: X5QG11

Facility ID: TNP53524

If continuation sheet Page 1 of 13

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER		& MEDICAID SERVICES			OMB NO.	0938-039
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  44C0001014	(X2) MULTIF A. BUILDING B. WING		(X3) DATE SI COMPLE	
, , , , , , , , , , , , , , , , , , , ,	OPY CENTER, THE		80	EET ADDRESS, CITY, STATE, ZIP CO 11 WEISGARBER RD NOXVILLE, TN 37950		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETION DATE
Q 002	This STANDARD Based on observation to deprete the out-patient surgical The facility failed to services were not hours of operation Center and the photographic to the Ambula single door with and the name of the Continued observationed observ	at with CMS to participate in SC, and must meet the in subparts B and C of this ry surgical center must comply a requirements.  Is not met as evidenced by: ation and interview, the facility a Ambulatory Surgery Center exclusive purpose of providing all services as a distinct entity of ensure common space and shared during overlapping of the Ambulatory Surgery sysician's office practices.	Q 002	Plan of Correction  The Endoscopy Center will of common spaces will only the Physician office is closs.  Systemic Changes  The physician office will be from 6:30AM to 11AM Meriday. The Endoscopy Center patients will be received as the physician office will be from 6:30AM to 11AM Meriday. The Endoscopy Center patients will be received as the physician of the space design and the space design of the patients. Discharging Center patients will occur for the patients. Discharging Center patients will occur for the patients will occur for the patients. This will occur for the patients will occur for the patients. This will occur for the patients will occur for the patients. This will occur for the patients will occur for the patients. This will occur for the patients will occur for the patients. This will be registration area. This will be registration area. This will be registration area.	ensure sharing occur when ed.  e closed daily onday through the will be same hours all Endoscopy ceived and gnated as the arrival of the of the occup through the rge area to of the	y
	receptionist windo in upon entry. Con the patients for the and the office prace lobby and called for within the same he Interview on April	ation revealed a sign on the windicating for patients to sign on tinued observation revealed a Ambulatory Surgery Center etice were seated in the main or procedures and office visits earing area of all in the lobby.  3, 2012, at 2:40 p.m., in the nursing station with Registered		01-2012.		

### PRINTED: 04/05/2012 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION TATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: IND PLAN OF CORRECTION A. BUILDING B. WING 44C0001014 04/04/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **801 WEISGARBER RD ENDOSCOPY CENTER.THE** KNOXVILLE, TN 37950 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Responsible Party and Monitoring Q 002 Continued From page 2 Q 002 Nurse (RN) #4 confirmed the RN would escort The Center Administrator or designee will the surgery center patients to the physician's ensure all physicians and staff are clinic exam room and review medical information. Continued interview confirmed the patient would educated to the required process then be escorted thru a door to the Ambulatory changes. The Center Administrator or Surgery Center "Waiting Area". designee will monitor activity daily for Interview in the Laboratory with the Laboratory the next 90 days to ensure there are no Assistant on April 3, 2012, at 2:00 p.m., revealed breeches. If 100% compliance is not "...the Surgery Center patients utilized the lab at the same time as the office patients..." obtained, action plans will be modified and the study will continue until 100% Interview in the office of the Administrator with the compliance is achieved for one Administrator on April 4, 2012, at 8:20 a.m., confirmed there was no clear and distinct consecutive period of 90 days is separation of space for patients presenting for a achieved. Staff will be advised any future procedure at the Ambulatory Surgery Center and breeches must be reported to the Center patients arriving for appointments at the physician's office practice. Continued interview Administrator for review and appropriate confirmed the Ambulatory Surgery Center actions. Results of all monitors will be patients shared the same lobby space at the same time as the physician's office practice reported at the regularly scheduled QAPI patients. Continued interview confirmed the meetings for reporting to the Governing surgery center patients received initial review of Body. medical history and status in the exam room of the physician's office practice before actually entering the Ambulatory Surgery Center. Continued interview confirmed there was no separation of lab usage for the surgery center

building.

Q 101

patients and the physician office patients.

Continued interview confirmed the laboratory is located in the physician's office area of the

416.44(a)(1) PHYSICIAL ENVIRONMENT

The ASC must provide a functional and sanitary environment for the provision of surgical services. Each operating room must be designed and

Q 101

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING		COMPLETED
	ROVIDER OR SUPPLIER	44C0001014	STRI 80	EET ADDRESS, CITY, STATE, ZIP CODE	04/04/2012
(X4) ID PREFIX TAG	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
Q 101	can be performed	the types of surgery conducted in a manner that protects the the physical safety of all	Q 101	Plan of Correction	
	Observation with room #1 on April	is not met as evidenced by: the Administrator in procedure 3, 2012, at 2;30 p.m., revealed with an expiration date of July		Expired items will be removed for patient care areas and will not be available for patient use.  Systemic Changes  Expired items have been discard	pe
	room #1 on April the culture swabs patient use. Observation on A tour, between 1:0 Endoscopy proce prep CytoLyt spec	Administrator in procedure 3, 2012, 2:30 p.m., confirmed were expired and available for pril 3, 2012, during the facility 0 p.m. and 3:00 p.m., in the dure room 7, revealed nine thin cimen bottles in the cabinet with e of October 2010.		cabinets and drawers in patient areas have been searched and a items removed. The unit mana inservice all procedure room as onwith regard responsibility to monitor all sup the room on a weekly basis. A supplies will be maintained in e	care all expired ger will sistants d to their oplies in list of each
Q 105	administrator, in the specimen bot for use. 416.44(c) EMERGE Emergency equiprooms must inclu (1) Emergency (2) Oxygen. (3) Mechanica equipment includ bag, and ventilato (4) Cardiac de	I ventilatory assistance ing airways, manual breathing or.	<del>Q 105</del>	procedure room. (See attached list) This list will be monitored the procedure room assistant a documented with date and sign. The unit manager will verify the completion of the weekly check monthly basis.  Responsible Party and Monitor.  The unit manager or designee responsible for developing a proom supply list. The unit man responsible for the education of the education of the education of the supply list.	weekly by and nature. e ks on a ing is rocedure ager is

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/05/2012 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING B. WING\_ 44C0001014 04/04/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **ENDOSCOPY CENTER, THE 801 WEISGARBER RD** KNOXVILLE, TN 37950 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Q 101 | Continued From page 3 Q 101 procedure room assistants regarding the equipped so that the types of surgery conducted supply checklist and their responsibility can be performed in a manner that protects the for weekly monitoring and lives and assures the physical safety of all documentation. The procedure room individuals in the area. assistants are responsible for monitoring supplies on a weekly basis and documenting completion of this task. This STANDARD is not met as evidenced by: The unit manager will monitor Observation with the Administrator in procedure completion of this task on a monthly room #1 on April 3, 2012, at 2:30 p.m., revealed 20 culture swabs with an expiration date of July basis. This responsibility will be added to 2011. the monthly Environment of Care rounds. Any variances/trends will be reported to Interview with the Administrator in procedure the QAPI committee. room #1 on April 3, 2012, 2:30 p.m., confirmed the culture swabs were expired and available for patient use Observation on April 3, 2012, during the facility tour, between 1:00 p.m. and 3:00 p.m., in the Endoscopy procedure room 7, revealed nine thin prep CytoLyt specimen bottles in the cabinet with an expiration date of October 2010. Interview with the Unit Manager and the facility administrator, in the procedure room, confirmed the specimen bottles were expired and available for use. Q 105 416.44(c) EMERGENCY EQUIPMENT Q 105

(2) Oxygen.

bag, and ventilator.

Emergency equipment available to the operating rooms must include at least the following:

(3) Mechanical ventilatory assistance equipment including airways, manual breathing

(5) Cardiac monitoring equipment.

Emergency call system.

(4) Cardiac defibrillator.

### PRINTED: 04/05/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 44C0001014 04/04/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **801 WEISGARBER RD ENDOSCOPY CENTER, THE** KNOXVILLE, TN 37950 SUMMARY STATEMENT OF DEFICIENCIES 10 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Q 105 | Continued From page 4 Q 105 Q 105 416.44(c) EMERGENCY (6) Tracheostomy set. EQUIPMENT (7) Laryngoscopes and endotracheal tubes. (8) Suction equipment. Plan of Correction (9) Emergency medical equipment and supplies specified by the medical staff. Expired medical supplies will be removed from the crash cart. A daily check list for both of the crash This STANDARD is not met as evidenced by: carts will be maintained and Based on observation, interview and review of facility policy, the facility failed to ensure expired documentation of daily checks will be medical supplies were removed from the crash completed. cart; failed to maintain daily check list for one of All expired laryngoscope batteries will be two crash carts within the facility; and failed to removed and replaced with batteries that ensure the batteries were not expired for two of are not expired. four laryngoscopes in one of the facility's two Emergency Carts. The findings included: Systemic Changes Observation on April 3, 2012, at 2:00 p.m., during A daily crash cart check list will be the facility tour, in the Endoscopy nurse's station. revealed expired Fast Patch Pads (defibrillator instituted for both crash carts that pads), dated 10/28/2011, in the top drawer of the include all crash cart items that have an crash cart. expiration date. The checklist will also 4 13 document that all patient care supplies Interview on April 3, 2012, at 2:05 p.m., with the are protected in plastic bags and the cart Unit Manager, in the nurse's station, confirmed is inspected for overall cleanliness. (See the Fast Patch Pads were expired and were attached crash cart check list) An RN will available for use.

ORM CMS-2567(02-99) Previous Versions Obsolete

Review of the facility policy Emergency Code

appropriately stocked and checked monthly on a

scheduled basis and all required checks will be

Observation on April 3, 2012, during the facility

documented on the Code Cart Checklist...",

Cart, revealed "...the code cart will be

Event ID: X5QG11

Facility ID: TNP53524

absence.

be assigned to perform and document

in the event of the first assigned RN's

daily checks of both of the crash carts. A

second RN will be assigned as a "back up"

If continuation sheet Page 5 of 13

ND PLAN OF CORRECTION	44C0001014	A. BUILDING B. WING		04/04	1/2012
NAME OF PROVIDER OR SUPPLIER ENDOSCOPY CENTER, THE		80	EET ADDRESS, CITY, STATE, ZIP CODE 11 WEISGARBER RD NOXVILLE, TN 37950		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
cart Daily Check List licensed nurse on the 2011, October 25, 20 and 31, 2011, and Da Interview on April 3, 2 unit manager, in the the crash cart checkl licensed nurse and the policy.  Review of the facility Equipment and Mainificensed nurse will be emergency cart on a of testing of equipment kept on the emergency Carts reviaryngoscope handles the insertion of a tube to allow for an airway expiration date of Ma Interview with the Add at 2:00 p.m., confirme in the laryngoscope handles the laryngoscope handles at 2:00 p.m., confirme in the laryngoscope handles at	m. and 3 p.m., in the tation, revealed the crash was not signed by a following dates: October 6, 211, November 10, 11, 14 ecember 12, 2011.  2012, at 1:40 p.m., with the nurse's station, confirmed ist was not signed by a ne facility failed to follow  policy Emergency tenance, revealed "a assigned to check the daily basisdocumentation in will be maintained in a log cy crash cart"  Administrator on April 4, fone of two of the facility's realed two of four (utilized to provide light in the throat of the patient with batteries with an rich 2005.  ministrator on April 4, 2012, and the batteries had expired andles.  RATION OF DRUGS	Q 105	Responsible Party and Monitor The unit manager or designee responsible for making the apprehanges to the crash cart check outlined above) and ensuring to checklist is present on both crash carts of the assigned RN (or the "backwill be responsible for complete checklist for both crash carts of basis. This RN will be responsible removing and replacing all explass needed. The unit manager of the completion of the crash cart challow and the monthly basis. This responsible added to the monthly Environmental Environmental Care rounds. Any variances/trabe reported to the QAPI committee.	will be propriate klist (as his ash carts. up" RN) sing the n a daily ble for ired items will be daily necklists on bility will onment of rends will	

### PRINTED: 04/05/2012 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA TATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: NO PLAN OF CORRECTION A. BUILDING B. WING. 04/04/2012 44C0001014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **A01 WEISGARBER RD** ENDOSCOPY CENTER, THE KNOXVILLE, TN 37950 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Q 181 Continued From page 6 Q 181 Q 181 416.48(a) ADMINISTRATION OF DRUGS This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure medications with a potential for Plan of Correction abuse were monitored for count; failed to ensure unused medications with a potential for abuse The Center will ensure that all were wasted per protocol; and failed to ensure to medications with a potential for abuse ensure expired medications were not available for will be monitored for count. patient use. The Center will ensure that all The findings included: medications with a potential for abuse will be wasted per protocol. Observation in the medication storage room with The Center will ensure that all pre-drawn the Administrator on April 3, 2012, at 2:10 p.m., revealed a four by six foot locked closet with syringes will be labeled with drug name, three shelves on three walls containing numerous dosage, date and time drawn up, date boxes of Propofol (Sedative/Anesthetic and time of expiration, and initials of medication). Continued observation revealed the person preparing the syringe. boxes contained 10 mg (milligram) vial, 20 mg The Center will ensure that all expired vials, and 50 mg vial of Propofol. Continued medications will not be available for observation revealed one medication reconciliation sheet (to be filled out every time a patient use. medication is removed and totaled to reflect the The Center will ensure that all remaining number of vials of medication) for medications are appropriately secured at Propofol 10 mg vial. Continued observation all times. revealed the sheet was incomplete and reflected the same remaining amount for numerous removals of medications and some removal of Systemic Changes

many vials were removed.

medications the lacked documentation of how

Interview in the medication storage room with the

Administrator on April 3, 2012, at 2:10 p.m., confirmed the medication reconciliation sheet was not accurately filled out and there were no sign out sheets for the 20 mg or 50 mg vials.

Center administrator or designee will conduct an inservice with all Center

CRNA's on \_\_\_\_\_regarding the

4/16

PRINTED: 04/05/2012 FORM APPROVED OMB NO. 0938-0391

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(X1) PROVIDER/SUPPLIER/CLIA

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

44C0001014

A. BUILDING B. WING

04/04/2012

NAME OF PROVIDER OR SUPPLIER

### ENDOSCOPY CENTER, THE

STREET ADDRESS, CITY, STATE, ZIP CODE 801 WEISGARBER RD KNOXVILLE, TN 37950

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE

### Q 181 Continued From page 7

Observation in procedure room #5 on April 3, 2012, at 10:00 a.m., with CRNA (Certified Registered Nurse Anesthetist) #1, revealed the 3 quart sharps container had two 10 ml (milliliter) containing approximately 4 ml of a milky colored substance present in the syringes.

Interview in procedure room #5 on April 3, 2012, at 10:00 a.m., with CRNA #1, confirmed the substance in the syringes was Propofol and the unused Propofol was to be disposed of by wasted or discarded it into the trash or sink to render it unavailable for further use.

Observation in procedure room #5 on April 3, 2012, at 10:00 a.m., with the Infection Control Preventionist revealed the following pre-drawn, undated or expired syringes of medication in an unlocked drawer: three 10 ml syringes labeled as Sodium Chloride 0.9% without a date as to when the medication was drawn into the syringes; one 10 ml syringes labeled as Sodium Chloride 0.9% with a n expiration date listed as March 6, 2012; and one 10 ml syringes labeled as Sodium Chloride 0.9% with an expiration dated listed as March 13, 2012.

Interview in procedure room #5 on April 3, 2012, at 10:00 a.m., with the Infection Control Preventionist confirmed the medications had expired and were available for patient use.

Observation with the Administrator on April 3, 2012, at 2:10 p.m., of one of two of the facility's Emergency Carts revealed six 10 ml vial of Amidate (short acting intravenous anesthetic agent) 20 mg (milligrams) per ml with an expiration date of March 1, 2012. Continued

Q 181

appropriate procedure for storage, accounting and disposal of Propofol to include the following: 1) Storage & Accounting - Propofol count sheets have been revised to include all Propofol dosages and an accounting of all boxes removed and returned. This will be documented by two licensed staff members. (See attached Propofol count sheet) The administrator or designee, along with a second licensed Center staff member will reconcile the Propofol count on a weekly basis. Any discrepancies will be reported to the Administrator. Propofol will be stored under double lock and the administrator or designee will maintain control of the keys. 2) Disposal - All unused Propofol not in the original unopened container is to be discarded in the appropriate receptacle.

All CRNA's and Center staff will receive training on safe injection practices through review of the CDC's "One and Only" campaign material by 05-01-2012. (See attached document)

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		44C0001014	B. WING		04/04/2012
	ROVIDER OR SUPPLIER		84	EET ADDRESS, CITY, STATE, ZIP CODE 01 WEISGARBER RD NOXVILLE, TN 37960	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE COMPLÉTION
	container situated contained one, aln 10 mg/ml.  Interview with the at 2:10 p.m., confidexpired and was a vial of Propofol hawasting the mediciper nursing protocomos and available one of the 2012.  Observation in propositive of the heart muscle), revealed one of the 2012.  Observation on Aptour, between 1:00 Endoscopy Room two Epinephrine (1 unlocked drawer a observation of protocopy Room two Epinephrine (1:10, unlocked drawer a linterview with the radministrator, at 2: room, confirmed the unlocked and unservooms and available.	ed the 8 gallon sharps next to the Emergency Cart rost full 20 ml vial of Propofol  Administrator on April 3, 2012, med the medication had vailable for patient use; and the d not been discarded by ation into the trash or sink the oil.  cedure room #8 with the pril 3, 2012, at 2:30 p.m., cure drawer in the room with vials of Epinephrine 1:10:000 a blood pressure and stimulate Continued observation a vials had expired April 1, ril 3, 2012, during the facility p.m. and 3:00 p.m., in the 6 Procedure room, revealed :10,000) 1mg/1ml (10ml), in an and unsecured. Continued cedure room 7 revealed one 000) 1mg/1ml (10cc) in an and unsecured.  secure manager and the facility 15 p.m., in the procedure e Epinephrine vials were in an cured drawer in the procedure e for use.	Q 181	All pre-drawn syringes will be liwith drug name, dosage, date and time of expand initials of person preparing syringe. All medication vials willabeled with date opened, date expiration, and the initials of the labeling the syringe.  All medications stored in the proof room supply/medication check checked for expiration date and appropriate secured storage. will be monitored weekly by the procedure room assistant and documented with date and sign All expired medications will be of per Center policy. The unit in will verify the completion of the cheeks on a monthly basis.  Responsible Party and Monitor  Center administrator will be refor conducting the inservice of CRNA's regarding the Center requirements relative to the approcedure for storage, account	and time piration, g the fill be e of ne person  rocedure edure list to be d This list e nature. disposed nanager e weekly ing sponsible all Center
Q 223	OWNERSHIP	TICE PHYSICIAN  disclose, where applicable,	0.223	disposal of Propofol. The Lead designee will be responsible for	CRNA or

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TAT	EME	ENT (	OF:	DEF	CIEN	CIES
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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

44C0001014

A. BUILDING B. WING

04/04/2012

NAME OF PROVIDER OR SUPPLIER

### **ENDOSCOPY CENTER, THE**

STREET ADDRESS, CITY, STATE, ZIP CODE **801 WEISGARBER RD** KNOXVILLE, TN 37950

SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG

PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY

COMPLETION

### Q 223 Continued From page 9

physician financial interests or ownership in the ASC facility in accordance with the intent of Part 420 of this subchapter. Disclosure of information must be in writing and furnished to the patient in advance of the date of the procedure.

This STANDARD is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the disclosure form of physician ownership was completed for four (#6, #12, #16, #18), and failed to ensure the disclosure form was current for five (#7, #15, #17, #19, #20) of twenty patients reviewed.

The findings included:

Medical record review revealed patient #6 was admitted to the tacility on January 3, 2012, to undergo colonoscopy. Continued medical record review revealed the form entitled Important Billing Information About Your Procedure was not present in the record

Medical regord review revealed patient #12 was admitted to the facility on November 8, 2011, to undergo a colonoscopy. Odntinued medical record review revealed the form entitled Important Billing Information About Your Procedure was not present in the record.

Medical record review revealed patient #16 was admitted to the facility on January 19, 2012, to undergo Endoscopic Ultraspund Upper. Continued medical record review revealed the form entitled Important Billing Information About Your Procedure was not present in the record.

conducting daily environmental audits for G 223 a period of two months (beginning 4-23-

2012) and random monthly audits ongoing to monitor the appropriate disposal of unused Propofol, appropriate labeling of all syringes and vials, and appropriate secured storage of all medications used by the anesthetists. CRNA non-compliance will be documented and reported by the Lead CRNA or designee and given to the QAPI committee. The QAPI committee report will be sent to the Governing Board.

All Center CRNA's are responsible for complying with the Center procedure for the storage, accounting and disposal of Propofol. All Center CRNA's are responsible for labeling all pre-drawn syringes and medication vials appropriately, as well as secured storage of all medications and disposal of expired medications.

All Center employees and CRNA's are responsible for reviewing the CDC "One and Only" campaign materials by 05-01-2012. The Administrator or designee is responsible for ensuring 100% compliance with review of this material by the Center employees and CRNA's by 05-01-2012.

The unit manager or designee is responsible for adding procedure room Fi medications to the procedure room supply/medication list. The unit manager

ige 10 of 10

STATEMEN AND PLAN (	T OF DEFICIENCIES OF CORRECTION	(X1) Pr	NOVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE S COMPLE	
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ENDOS	PROVIDER OR SUPPLIER		*		8	REET ADDRESS, CITY, STATE, ZIP CODE 101 WEISGARBER RD KNOXVILLE, TN 37950	1 04/0	412012
PREFIX TAG	(EACH DEFICIENC)	MUST	OF DEFICIENCIES SE PRECEDED BY FULL TIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE
Q 223	physician financial ASC facility in accordance of this subchapmust be in writing a advance of the date. This STANDARD is Based on medical the facility failed to physician ownership #12, #16, #18), and disclosure form was #19, #20) of twenty. The findings include.	interes rdance oter. D and furre of the s not m record ensure o was o failed s currel patient	net as evidenced by: review and interview, the disclosure form of completed for four (#6, to ensure the nt for five (#7, #15, #17, is reviewed.	Q 18 Cun	1	is responsible for the education procedure room assistants registed supply/medication checklist are responsibility for weekly monit documentation of expiration of well as secured storage of this medication. The unit manager monitor completion of this tas monthly basis. This responsible added to the monthly Environic Care rounds. Any variances/tribe reported to the QAPI comme	rarding the and their toring and dates as will sk on a lility will be ment of rends will nittee.	
	admitted to the facili undergo colonoscop review revealed the Information About Y present in the record Medical record review admitted to the facili undergo a colonoscopic record review reveal Billing Information A present in the record Medical record review admitted to the facili undergo Endoscopic Continued medical record review admitted to the facili undergo Endoscopic Continued medical record review admitted to the facili undergo Endoscopic Continued medical record review admitted to the facili undergo Endoscopic Continued medical record review admitted to the facili undergo Endoscopic Continued medical record review admitted to the facili undergo Endoscopic Continued medical record review admitted to the facili undergo Endoscopic Continued medical record review admitted to the facili undergo Endoscopic Continued medical record review admitted to the facili undergo Endoscopic Continued medical record review admitted to the facili undergo Endoscopic Continued medical record review admitted to the facili undergo Endoscopic Continued medical record review admitted to the facili undergo Endoscopic Continued medical record review admitted to the facili undergo Endoscopic Continued medical record review admitted to the facili undergo Endoscopic Continued medical record review admitted to the facili undergo Endoscopic Continued medical record review admitted to the facili undergo Endoscopic Continued medical record review admitted to the facili undergo Endoscopic Continued medical record review admitted to the facili undergo Endoscopic Continued medical record review admitted to the facili undergo Endoscopic Continued medical record review admitted to the facili undergo Endoscopic Continued medical record review admitted to the facili undergo Endoscopic Continued medical record review admitted to the facili undergo Endoscopic Continued medical record review admitted to the facili undergo Endoscopic Continued medical record review admitted to the facili undergo Endoscopic Continued medical record review admitted to	ew reverse ty on July	tinued medical record ntitled Important Billing ocedure was not saled patient #12 was lovember 8, 2011, to ontinued medical form entitled Important our Procedure was not saled patient #16 was anuary 19, 2012, to ound Upper, eview revealed the out of the	Q 22.5	3	PHYSICIAN OWNERSHIP  Plan of Correction  The Center will ensure the documentation of receipt of intrelative to the disclosure of physician ownership by every patient at a patient visit.  Systemic Changes  Physician ownership disclosure information will be given to and discussed with each patient at Center visit. (See attached multi authorization form). At each standard content of the content o	formation ysician every d d their initial tiple	

TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PRO	VIDER/SUPPLIER/CLIA TIFICATION NUMBER:	A. BUI	LDING		(X3) DATE SUI COMPLET	
			44C0001014	B WIN	IG		04/04	/2012
	ROVIDER OR SUPPLIER				80	EET ADDRESS, CITY, STATE, ZIP CODE 11 WEISGARBER RD NOXVILLE, TN 37950		
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Q 223	Medical record readmitted to the faundergo a Sigmo Ultrasound Upper review revealed to Information About present in the record readmitted to the faundergo colonos review revealed to was dated Nover updated for the colonos review revealed to the faundergo Esophalupper gastrointed to the faundergo Esophalupper gastrointed record review reverecord was dated not been updated.  Medical record readmitted to the faundergo Esophalupper gastrointed record review reverecord was dated not been updated.	view reversitity on Fridoscopy r. Continume for entity or Proportion redure converse been in who is reserved in ( review reversitity on Jopen Continument proposer 4, 2011 review reversitity on Jopen Continument proposer 4, 2011 review reversitity on Jopen Continument proposer 4, 2011 review reversities and tracket in Jopen Continument proposer 4, 2011 review reversities of the continument	ed medical record itled Important Billing cedure was not ant Billing Information tained the disclosure formed by the staff endering services has mamed facility)".  ealed patient #7 was anuary 11, 2012, to tinued medical record on the record of 11, and was not cedure.  ealed patient #15 was December 9, 2011, to tinued medical record of the patient was not cedure.	Q	223	visit, the information will be diwith the patient, and the patient asked to sign and date the same authorization form indicating the continued understanding and a with its contents. The patient their own copy of the updated authorization form at each visit Confirming the presence of passignature and date on the multiauthorization form will be addited medical record audit. Center sinserviced by the administrator designee on 04-20-2012 regard process.  Responsible Party and Monitor The administrator or designee responsible for inservicing the regarding the process for obtain confirmation of patient receipt understanding of physician ow disclosure information. The Ceis responsible for ensuring that have reviewed the physician ow disclosure at each Center visit, member(s) responsible for medical will report any trends/valthe QAPI committee. The QAPI committee report will be sent to Governing Board.	nt will be ne multiple heir agreement will receive multiple t. tient tiple ed to the staff will be r or ding this  ing will be staff ning and nership enter staff patients wnership The staff dical chart riances to	4/11

	OF DEFICIENCIES F CORRECTION		VIDER/SUPPLIER/CLIA DIFICATION NUMBER:  44C0001014	A. BUII	DING		COMPLET	
	OPY CENTER, THE				80	EET ADDRESS, CITY, STATE, ZIP CODE 11 WEISGARBER RD NOXVILLE, TN 37950		
(X4) ID PREFIX TAG	(EACH DEFICIENCE	CY MUST BE	F DEFICIENCIES PRECEDED BY FULL FYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE	(X8) COMPLETION DATE
Q 223	undergo Esophage Endoscopic Ultras medical record reform in the record and had not been procedure.  Medical record readmitted to the faundergo colonoscreview revealed the was dated Decenupdated for the conference reconfirmed the discinct the disclosure for patients #7, #15, interview the assidisclosure form should be presenupdated for each 416.51(b) INFECT The ASC must make infections and conaddition, the infections and conaddition, the infectionally recognitionally recognitionally recognitions.	view reversitive on Months and the disclosion of	per. Continued aled the disclosure d January 11, 2012, or the current aled patient #20 was arch 5, 2012, to inued medical record ure form in the record 011, and had not been bedure.  2012, at 3:10 p.m., in ssistant administrator rms were not present 3, #12, #16, #18, and been updated for #20. In continued histrator confirmed a ligned by each patient; cord; and should be a ligned by each patient; and ligned by each patient.		2223	Q 242 416.51(b) INFECTION COPROGRAM  Plan of Correction  The Center will ensure that all sare maintained in good repair. The Center will maintain that a in procedure rooms are maintained good repair.  The Center will ensure that all so in procedure rooms are maintained good repair.  The Center will ensure that all so in procedure rooms are maintained good repair.	stretchers Il cabinets ined in	
			interview, the facility			care items have not expired.		

### PRINTED: 04/05/2012 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION TATEMENT OF DEFICIENCIES COMPLETED ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 04/04/2012 44C0001014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 801 WEISGARBER RD ENDOSCOPY CENTER, THE KNOXVILLE, TN 37950 (X5) PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY Systemic Changes 0 242 Q 242 Continued From page 12 failed to ensure one of eight stretchers were The stretcher pad identified as being in maintained in good repair to allow cleaning; failed disrepair has been discarded. All Center to ensure one cabinet in one of eight procedure rooms was maintained in good repair to allow stretcher pads have been evaluated by 511 cleaning; and failed to ensure patient care the manufacturer's representative. All supplies had not expired in one of eight pads that can be restored will be restored procedure rooms. by the manufacturer. All pads deemed as unable to be restored will be discarded The findings included: by 05-01-2012. Observation in the post-operative area with Registered Nurse #1, on April 3, 2012, at 9:40 All supply cabinets with visible rust have a.m., revealed a patient stretcher with thread been removed from patient care areas. bare, dime sized areas of the protective covering 511 All cabinets are scheduled to be of the foam mattress pad at head and waist level. evaluated by the building contractor on Interview with Registered Nurse #1, on April 3, 4-17-2012. Repair or replacement will be 2012, at 9:40 a.m., confirmed the stretcher was in completed for all cabinets in question by use and the breeches in the protective covering 05-01-2012. made it impossible to clean the mattress pad between patient use. All stretchers and stretcher pads as well Observation with Medical Assistant (MA) #1 in as all Center furnishings will be evaluated procedure room #5 on April 3, 2012, at 9:45 a.m., by the Center Administrator or designee revealed a bedside supply cabinet to have rust for being in good repair. Evaluation of covering the handle areas of all three drawers. patient care stretchers and Center furnishings will be added to the monthly Interview with the Infection Control Preventionist **Environment of Care rounds.** in procedure room #5 on April 3, 2012, at 10:20 a.m., confirmed the rusted areas were unable to Expiration dates will be monitored for all be cleaned. patient care items (See plan of correction

for Q101 416.44(a)(1) )

Cont

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE	& MED	ICAID SERVICES				OMB NO.	0930-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PR	OVIDER/SUPPLIER/CLIA NTIFICATION NUMBER:	(X2) M A. BUII B. WIN	DING	E CONSTRUCTION	(X3) DATE SU COMPLE	TED
NAME OF PI	ROVIDER OR SUPPLIER	L	44C0001014	D. AAII	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		4/2012
ENDOSC	OPY CENTER, THE					1 WEISGARBER RD NOXVILLE, TN 37950		
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Q 242	failed to ensure on maintained in good to ensure one cab rooms was maintained in good to ensure one cab rooms was maintained in good to ensure one cab rooms was maintained in the findings included t	de of eigenerinet in of ined in of to ensiste in the ined in ded:  post-on #1, on attent sereas of ess pad istered, confirmed in the ined	to allow cleaning; failed ne of eight procedure good repair to allow ure patient care n one of eight	Q	242	Responsible Party and Monit  The Administrator or designer responsible for evaluation of patient stretchers and Center to ensure that they are in good items found to not be in good be either restored or replace manufacturer.  The Unit manager or designer responsible for adding evaluation patient stretchers and Center to the Environment of Care accompleted on a monthly base found to be in disrepair will and restored or replaced. The Environment of Care report to the QAPI committee.	ee will be fall Center furnishings od repair. A d repair will ed by the ee is ation of all er furnishings rounds sis. Any item be removed he monthly	

PRINTED: 04/05/2012 FORM APPROVED

Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING\_ 04/04/2012 TNP53524 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 801 WEISGARBER RD ENDOSCOPY CENTER, THE KNOXVILLE, TN 37950 (X5) COMPLETE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) A 002 A 002 1200-8-10 No Deficiencies During the Licensure survey conducted on April 3 - 4, 2012, at The Endoscopy Center, no deficient practices were cited under Chapter 1200-8-10, Standards for Ambulatory Surgery Treatment Centers. livision of Health Care Facilities TITLE (X6) DATE ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TATE FORM If continuation sheet 1 of 1 X5QG11

### PRINTED: 04/05/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED ND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN B. WING\_ 44C0001014 04/04/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **801 WEISGARBER RD ENDOSCOPY CENTER.THE** KNOXVILLE. TN 37950 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) 1D (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 144 416.44(b)(1) LIFE SAFETY CODE STANDARD K 144 418.44(b)(1) LIFE SAFETY CODE K 144 STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in Plan of Correction accordance with NFPA 99. 3.4.4.1, NFPA 110. 8.4.2 The Center will provide battery-powered emergency lighting in the auto transfer This STANDARD is not met as evidenced by: switch location. NFPA 110 (1999) The Center will ensure that the 5-3 Lighting. emergency generator is provided with a 5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered remote annunciator in a continuously emergency lighting. The emergency lighting occupied area. charging system and the normal service room Systemic Changes lighting shall be supplied from the load side of the transfer switch. The Center Administrator will coordinate Based on observation and interview, the facility failed to provide Battery-Powered Emergency with an electrician to assess and provide Lighting in the Auto Transfer Switch location. a quote to install back up emergency The findings include: 5/19 lighting in the generator emergency Observation and interview with the Financial Administrator on April 4, 2012 at 10:10 a m transfer switch location. This will be confirmed the Auto Transfel Switch room was not completed no later than 05-18-2012. provided with battery-powered emergency lighting. The Center Administrator will coordinate Based on observation and interview, the facility failed to assure the emergency generator was with an electrical engineer to assess all provided with a remote annunciator in an requirements associated with placement continuously occupied area. (2000 NFPA 99, of a remote annunciator for the back-up -4.1.1.15). The findings include: generator in a continuously occupied

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Observation and interview with the Financial

Administrator on April 4, 2012 at 11:15 a.m.

confirmed the emergency generator was not

These findings were verified by the Financial Administrator and acknowledged by the

provided with a remote annunciator

TITLE

area of the Endoscopy Center. The

expected completion date is 05-18-2012.

(X6) DATE

ny deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 lys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

	OF DEFICIENCIES OF CORRECTION		VIDER/SUPPLIER/CLIA TIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G 01 - MAIN	(X3) DATE SI COMPLE	
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K 144		_	t conference on April	K 144	Responsible Party and Mo The Center Administrator work is scheduled and cordesignated time. Once ins Center Administrator or demonitor or test the function annunciator panel at least month. This responsibility to the Center EOC checklis	will ensure all inpleted in the talled, the esignee will on of the one time per will be added	

FORM APPROVED Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN B. WING TNP53524 04/04/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **801 WEISGARBER RD ENDOSCOPY CENTER.THE** KNOXVILLE, TN 37950 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE CXALID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) A 801 1200-8-10-.08 (1) Building Standards A 801 A 801 1200-8-10-08 (1) BUILDING **STANDARDS** (1) An ASTC shall construct, arrange, and maintain the condition of the physical plant and the overall ASTC environment in such a manner Plan of Correction that the safety and well-being of the patients are assured All fire/smoke barriers and associated openings will meet NFPA 101 Life Safety Code 2000 Edition This Rule is not met as evidenced by: NFPA 101 (Life Safety Code 2000 edition) Systemic Changes 8.2.3.2.3.1 Every opening in a fire barrier shall be The Center Administrator will coordinate protected to limit the spread of fire and restrict the movement of smoke from one side of the fire assessment of the existing fire barriers by barrier to the other. The fire protection rating for a licensed architect and contractor on opening protectives shall be as follows: 5/19 4/17/2012 to determine current fire (1) 2-hour fire barrier - 11/2-hour fire protection rating rating status. If it is determined existing (2) 1-hour fire barrier - 1-hour fire protection doors do not meet the same standard as rating where used for vertical openings or exit the fire barrier, replacements will be enclosures, or 3/4-hour fire protection rating where used for other than vertical openings or obtained and installed no later than 05exit enclosures, unless a lesser fire protection 18-2012 rating is specified by Chapter 7 or Chapters 11 through 42 Responsible Party and Monitoring Based on observation and record review, the facility failed to the assure the building fire walls were constructed as specified on the architectural The Center Administrator will ensure all plans. require corrections take place in the

vision of Health Care Facilities

The findings include:

TITLE

timeframes as defined.

(X6) DATE

Administrator of occupancy separation wall doors on April 4, 2012 at 11:00 a.m. confirmed 2 of 4 of

Observation and review of the architectural plans, with the Financial Administrator, on April 4, 2012

at 11:00 a.m. confirmed the occupancy separation walls were shown as a 2-hour fire rated wall on the architectural plans with 4 of 4 fire rated doors specified as having a 90 minutes

fire rating. Observation with the Financial

X5QG21

PRINTED: 04/05/2012 FORM APPROVED Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN B. WING\_ 04/04/2012 TNP53524 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **801 WEISGARBER RD** ENDOSCOPY CENTER, THE KNOXVILLE, TN 37950 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PROVIDER'S PLAN OF CORRECTION (X4) ID ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) A 801 A 801 Continued From page 1 the doors near the waiting room were rated for 20 minutes This finding was verified by the Financial Administrator and acknowledged by the Administrator during the exit conference on April 4, 2012.

ivision of Health Care Facilities TATE FORM

X5QG21

# **AAAHC - Standard Survey Report**

## 2012 AAAHC Survey Report



### Laurence Hausman MD

## Garry Feld BA, MS, FACHE

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2012 AAAHC Survey Report - Organization ID: 13979 page 1 of 75

# Information Regarding the AAAHC Survey Report

This Survey Report is used in conjunction with the 2012 Accreditation Handbook for Ambulatory Health Care. This Survey Report reflects an evaluation of the organization's compliance with the standards as stated in the Handbook

## **Evaluation of the Standards**

SC -- Substantial Compliance indicates that the organization's current operations are acceptable and meet the standards. May require supporting comments to clarify or elaborate.

PC -- Partial Compliance indicates that a portion of the item is acceptable, but other areas need to be addressed. Requires supporting comments,

NC -- Non-Compliance indicates that the organization's current operations do not meet the standards. Requires supporting comments.

N/A -- Not Applicable indicates that the standard does not apply to the organization.

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5250 Old Orchard Road, Suite 200

Skokie, IL 60077

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References are made throughout this Survey Report to the Life Safety Code® and to NFPA 101®. Both are registered trademarks of the National Fire Protection Association, Quincy, Massachusetts.

The pronouns used in the Survey Report were chosen for the ease of reading. They are not intended to exclude reference to either gender

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Previous Deficiencies	cies					
Chapter	Standard	Previous Compliance Level	Previous Comment	Current Compliance Level	Current Comment	Deficiency Comment
1 - Rights of Patients	а	PC	In the pre and post-op areas, the bays are separated by curtains, and in the main facility it was observed that curtains are not pulled, even when a nurse is at the bedside.	SC	Individual exam rooms are utilized for admitting the patients and a procedure room divided by a screen to allow for 2 patients was used as immediate pre-op evaluation rooms.	
3 - Administration	B4	PC	Annual appraisals and current competencies were found in reviewed files. However, the Medical Director does not undergo performance evaluation, even though he is compensated.	PC	While all employees had received annual appraisals during their tenure, not all employees had timely appraisals available for review in the employee personnel files. One appraisal was from 2007 and another from 2009.	
5 - Quality Improve II	∢	PC	There is a regularly reviewed QI program based on the AmSurg model. However, there is no evidence that the satellites have done any studies specific to their centers.	sc	The center has adopted the QAPI Program developed by AmSurg.	
5 - Quality Improve II	A-6	РС	There is no evidence that the satellites have done any studies specific to their centers. The organization has done few studies.	SC	QI studies have come from benchmarking activities at this center.	
5 - Quality Improve II	B-5	РС	In one of the studies reviewed, statistical analysis was not demonstrated.	sc		
5 - QI Studies Ila	Q11-5	PC	The study did not demonstrate statistical analysis.	SC	Data analysis done.	
8 - Facilities	A-2	РС	Some minor LSC deficiencies are	SC	The Endoscopy Center	

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			present. For example, atthough exit signs are present, there is no evidence of an annual 90-minute test as required by the LSC. The facility was surveyed by the state of Tennessee in 2007 with no deficiencies noted.		has undergone several CMS inspections and has aggressively corrected noted deficiencies. One exception was the Feb 12 CMS report directed weekly inspection of security of all fire doors. The organization had yet to implement weekly implement weekly implement weekly correctly but did connectly but did conduct monthly checks.	
8 - Facilities	9 9	S	See comment at Standard 1.B.	SC	While patient treatment/interaction areas have privacy curtains, during the facility walk through at the North satellite, not all curtains were closed during staff patient interactions.	
8 - Facilities	Я	PC	The main facility has a diesel powered generator, but the cap for filling the tank was noted to be not secured. There is no evidence that exit signs undergo an annual test.	SC		

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Satellite	Satellite Facilities Overview	erview		
Standard	CMS		Compliance Rating	Comments
-		Does the organization have more than one facility?	Yes	
2		If the organization has more than one facility, list those that are to be included in the accreditation.		The Endoscopy Center, LLC - North629 Delozier WayPowell, TN 37849The Endoscopy Center, LLC - West11440 Parkside Drive, Suite 100Knoxville, TN 37934
м		List the names and addresses of the satellite location that were reviewed.		The Endoscopy Center, LLC - North629 Delozier WayPowell, TN 37849The Endoscopy Center, LLC - West11440 Parkside Drive, Suite 100Knoxville, TN 37934
4		Provide a brief description of the satellite locations reviewed during the survey, including information on the quality of care rendered, clinical records, and facilities and environment. If applicable, also include information on pharmaceutical services, pathology and medical laboratory services, diagnostic and therapeutic imaging, occupational health services, surgical services, and anesthesia services.		The Main location is where most of the endoscopy procedures are performed. All of the physicians rotated to the two satellite facilities. Identical services are provided at these locations. There are two procedure rooms and adequate clinical support space at these locations. Both facilities are well maintained and have Center Managers who report to the RN Administrator.

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Chapter	Chapter 1 - Rights of Patients	Patients		
Standard	CMS		Compliance Rating	Comments
		An accreditable organization recognizes the basic human rights of patients. Such an organization has the following characteristics.		
		Overall Chapter Compliance Level	SC	Patients are treated with dignity and respect from the moment they arrive through discharge. They are afforded privacy throughout. In this busy practice, all patients encountered seemed pleased.
А		Patients are treated with respect, consideration, and dignity.	SC	Patients are treated well though-out their stay. All clinical areas are private and clean
<b>a</b>		Patients are provided appropriate privacy.	sc	Individual exam rooms are utilized for admitting the patients and a procedure room divided by a screen to allow for 2 patients was used as immediate pre-op evaluation rooms.
S		Patient disclosures and records are treated confidentially, and patients are given the opportunity to approve or refuse their release, except when release is required by law.	sc	All records are stored on a password protected electronic record system.
Q	,	Patients are provided, to the degree known, complete information concerning their diagnosis, evaluation, treatment, and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.	SC	Patients sign a consent form that explains the risks and benefits of the procedure and one that explains the risks of anesthesia. They are also given brochures discussing the procedure. They are given the opportunity to ask questions.
ш		Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.	sc	
IL.		Information is available to patients and staff concerning:	sc	Patients are made aware of the center's patients bill of rights,
7-		Patient rights, including those specified in A, B, C, D, and E above	SC	Patient rights and responsibilities are printed in a brochure and sent to the patient preoperative.
F-2		Patient conduct, responsibilities and participation	SC	Patients are given ample information regarding their responsibilities and participation in health care.
F-3		Services available at the organization	sc	GI services offered at this center are well delineated.
4		Provisions for after-hours and emergency care	SC	There is a phone number on the door of the center to call during after hours. There is a live operator answering all those after hour calls, and a physician is on-call 24 hours a day.

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F-5		Fees for services	သွ	Patients are made aware of fees and insurance coverage.
F-6		Payment policies	SC	Patients are given paperwork regarding payment policies at the center.
F-7	u.	Patient's right to refuse to participate in experimental research	NA	
F-8	4	Advance directives, as required by state or federal law and regulations	sc	Advance directives are not honored at the center.
F-9		The credentials of health care professionals.	SC	Credentials of the providers are immediately available to the patients. The patients are mailed a brochure outlining the qualifications of all the medical staff.
O	ш.г	Prior to receiving care, patients are informed of patient responsibilities. These responsibilities require the patient to:	SC	
<u>-</u> -		Provide complete and accurate information to the best of his/her ability about his/her health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities	SC	Patient is queried regarding these issues both before arriving at the center, and then again several times the day of the procedure.
G-2		Follow the treatment plan prescribed by his/her provider and participate in his/her care	SC	Printed brochures are made available to the patient pre-procedure, and discharge instructions are given to the patient.
6-3		Provide a responsible adult to transport him/her home from the facility and remain with him/her for twenty-four (24) hours, if required by his/her provider	SC	The center requires an adult escort home. During the procedure observed, the patient was asked several times regarding who would be escorting him home.
6-4		Inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care	SC	The center does not honor advanced directives.
6-5		Accept personal financial responsibility for any charges not covered by his/her insurance	SC	Financial responsibility of the patient is clearly outlined. In a brochure mailed to the patients pre-procedure, the patients are encouraged to ask any questions they have regarding financial responsibilities.
9-9		Be respectful of all the health care professionals and staff, as well as other patients.	SC	This is clearly delineated in the patient bill of rights.
I		Patients are informed of their right to change their provider if other qualified providers are available.	SC	
-		Representation of accreditation to the public must accurately reflect the AAAHC-accredited entity.	SC	The AAAHC Certificate is prominently displayed in the holding area.
7		Marketing or advertising regarding the competence and capabilities of the organization is not misleading to patients.	SC	The marketing materials were honest and forthright. They did not make any false claims.
¥		Patients are provided with appropriate information regarding the absence of malpractice insurance coverage.	NA NA	All physicians carry malpractice insurance.

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1	Patients are informed about procedures for expressing suggestions, complaints and grievances, including those required by state and federal regulations.	SS	Patients are given a clear pathway to file complaints and/or grievances.
	Consultative Comments		Consultative Comments

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Chapter	2 - Governar	Chapter 2 - Governance - General Requirements I		
Standard	CMS		Compliance Rating	Comments
		An accreditable organization has a governing body that sets policy and is responsible for the organization. Such an organization has the following characteristics.		
		Overall Chapter Compliance Level	sc	
		Subchapter I - General Requirements: This subchapter describes general requirements for an organization and its governing body.	SC	
٨		The organization is a legally constituted entity, or an organized sub-unit of a legally constituted entity, or is a sole proprietorship in the state(s) in which it is located and provides services.	sc	
A-1		The names and addresses of all owners or controlling parties (whether individuals, partnerships, trusts, corporate bodies or subdivisions of other bodies, such as public agencies or religious, fratemal, or other philanthropic organizations) are available upon request and furnished to the Accreditation Association for Ambulatory Health Care, Inc (AAAHC)	SC	The organization is a legal corporation in the state of Tennessee, owned by AmSurg (51 %) and a group of gastroenterologists (49%).
A-2		A legally constituted entity is documented by at least one of the following: articles of organization, articles of incorporation, partnership agreement, operating agreement, legislative or executive act, or bylaws, unless the organization is a sole proprietorship	SC	
В		The governing body addresses and is fully and legally responsible, either directly or by appropriate professional delegation, for the operation and performance of the organization. Governing body responsibilities include, but are not limited to:	SC	Two AmSurg administrators and two physician/owners compose the governing body. The on-site management team attend all board meetings.
B-1		Determining the mission, goals, and objectives of the organization	sc	Organization mission, goals, and objectives are present.
B-2		Ensuring that facilities and personnel are adequate and appropriate to carry out the mission	SC	By observation the facility and staffing patterns at each location support the mission and needs of the organization.
B-3		Establishing an organizational structure and specifying functional relationships among the various components of the organization	SC	An organizational chart was present to show functional relationships.
B-4		Adopting bylaws or similar rules and regulations for the orderly development and management of the organization	sc	
B-5		Adopting policies and procedures necessary for the orderly conduct of the	SC	

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	organization, including the organization's scope of clinical activities		
B-5a	The organization develops and maintains a policy defining the care of pediatric patients, if relevant, specific components of perioperative care are listed in Standard 10.1.X.	WA	The center does not treat any pediatric patients.
B-6	Ensuring that the quality of care is evaluated and that identified problems are appropriately addressed	SC	
B-7	Reviewing all legal and ethical matters concerning the organization and its staff and, when necessary, responding appropriately	SC	
B-8	Maintaining effective communication throughout the organization, including ensuring a linkage between quality management and improvement activities and other management functions of the organization	SC	
B-9	Establishing a system of financial management and accountability appropriate to the organization	SC	The organization uses the financial system for tracking financial performance and data.
B-10	Determining a policy on the rights of patients	SC	The Operating Board has approved a policy which addresses the rights of center patients.
B-11	Approving and ensuring compliance of all contracts or arrangements affecting the medical and dental care provided under its auspices and ensuring that services are provided in a safe and effective manner, including, but not limited to, those concerning:	SC	There are written contracts with companies to provide goods and services.  These contracts are reviewed annually by management or when needed.
B-11a	The employment or contracting of health care professionals	SC	
B-11b	The provision of radiology services and pathology and medical laboratory services	SC	
B-11c	The use of external laboratories	SC	
B-11d	The provision of care by other health care organizations, such as hospitals	SC	There is a written transfer agreement with a local health system.
B-11e	The provision of education to students and postgraduate trainees	NA A	
B-11f	The provision of after-hours patient information or telephone triage services, including the review of protocols	SC	This is covered in the written discharge instructions given to each patient post-procedure.
B-11g	The Centers for Medicare & Medicaid Services (CMS) requirements, if the organization participates in the Medicare/Medicaid program	SC	One satellite center had to do construction to meet the CMS facility standard for Medicare. The renovation/construction has been completed but the State has not conducted a site visit to approve the facility changes.
B-11h	The policies/procedures related to utilization, quality improvement, risk	NA A	

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	management, credentialing, patient rights, etc., of a managed care organization, if the organization/provider has contracts with managed care organizations		
B-11i	The activities or services delegated to another entity.	sc	
B-12	Formulating long-range plans in accordance with the mission, goals, and objectives of the organization	SC	The board does long range planning with support and guidance from AmSurg staff.
B-13	Operating the organization without violating federal or state anti-discrimination laws	SC	
B-14	Ensuring that all marketing and advertising concerning the organization does not imply that it provides care or services that it is not capable of providing	SC	
B-15	Developing a program of risk management appropriate to the organization	SC	The center risk management program is supported by AmSurg Corporate risk management staff.
B-16	Determining a policy on continuing education for personnel and/or patient education for members/enrollees, if applicable	SC	
B-17	Developing policies that comply with all applicable occupational health and safety regulations for health care workers, such as the Occupational Safety and Health Administration (OSHA) rules on Occupational Exposure to Bloodborne Pathogens (Title 29 CFR 1910.1030)	SC	
B-18	Establishing a mechanism to fulfill all applicable obligations under local, state and federal laws and regulations, such as those addressing disabilities, medical privacy, fraud and abuse, self-referral and reporting to the National Practitioner Data Bank (NPDB)	SC	
B-19	Development, implementation and oversight of the organization's infection control and safety programs to ensure a safe environment of care	SC	The organization has written infection control and safety programs which have been approved by the Operating Board which provides oversight in these areas.
B-20	Adopting policies/procedures to resolve grievances and external appeals, as required by state and federal law and regulations	SC	
B-21	Establishing processes for the identification, reporting, analysis, and prevention of adverse incidents and ensuring consistent and effective implementation by developing a system that includes:	SC	Based on observations and discussions with AmSurg staff, this organization has established a process for the minimization and prevention of incidents. The process includes the identification, analysis and appropriate corrective action plans.
B-21a	Definition of an adverse incident that, at a minimum, includes:	SC	
B-21a-i	An unexpected occurrence during a health care encounter involving	SC	

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									The Operating Board meets quarterly and minutes reflect items below. The minutes are well documented.
	SC	SC	SC	SC	SC	SC	SS	SC	သွ
patient death or serious physical or psychological injury or illness, including loss of limb or function, not related to the natural course of the patient's illness or underlying condition	Any process variation for which a recurrence carries a significant chance of a serious adverse outcome	Events such as actual breaches in medical care, administrative procedures or other events resulting in an outcome that is not associated with the standard of care or acceptable risks associated with the provision of care and service for a patient	Circumstances or events that could have resulted in an adverse event	Review of frequency of occurrences, severity of outcomes and reportable events	A process for conducting a thorough analysis when an adverse incident occurs in order to identify the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of an adverse incident; the analysis identifies potential improvements in processes or systems that would tend to decrease the likelihood of such incidents in the future, or determines, after analysis, that no such improvement opportunities exist	A process for reporting adverse incidents through established channels within the organization and, as appropriate, to external agencies in accordance with law and regulation	An action plan that identifies the strategies that the organization intends to implement to reduce the risk of similar incidents occurring in the future, the plan should address responsibility for implementation, oversight, pilot testing as appropriate, time lines, and strategies for measuring the effectiveness of the actions	Accredited organizations must notify the AAAHC in writing within fifteen (15) calendar days of significant organizational, ownership, operational or quality of care events, including criminal indictment, guilty plea or verdict in a criminal proceeding (other than a traffic violation) involving directly or indirectly the organization or any of its officers, administrators, physicians/health care professionals, or staff within their role in the organization. Any such changelevent that negatively affects the public's perception of the accredited organization or AAAHC, as the accrediting body, must also be reported. An organization's duty to provide this information continues during the entire accreditation term.	The governing body meets at least annually and keeps such minutes or other records as may be necessary for the orderly conduct of the organization.
	B-21a-ii	B-21a-iii	B-21a-iv	B-21b	B-21c	B-21d	B-21e	O	D

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											Consultative Comments	Suggest the Operating Board develop a management succession plan for the organization.
sc	sc	sc	sc	sc	sc	SC	sc	SC	SC	သွ		
Items to be reviewed should include, but are not limited to:	Rights of patients	Delegated administrative responsibilities	Quality of care	The quality management and improvement program	The organization's policies and procedures	The appointment/reappointment process	The infection control program	The safety program	Compliance with all other applicable standards	If the governing body elects, appoints or employs officers and administrators to carry out its directives, the authority, responsibility, and functions of all such positions are defined.	Consultative Comments	
D-1	D-1a	D-1b	D-1c	D-1d	D-1e	D-1f	D-1g	D-1h	D-1i	Ш		

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	Comments				Seven physicians and three CRNAs.	The Operating Board has established specific criteria for credentialing and privileging.			
	Compliance Rating		SC	10		SC	SC	sc	SC
Chapter 2 - Governance - Credentialing and Privileging II		Credentialing is a three-phase process of assessing and validating the qualifications of an individual to provide services. The objective of credentialing is to establish that the applicant has the specialized professional background that he or she claims and that the position requires. An accreditable organization:  1) establishes minimum training experience and other requirements (i.e., credentials) for physicians and other health care professionals; 2) establishes a process to review, assess and validate an individual's qualifications, including education, training, experience, actification, licensure and any other competence-enhancing activities, against the organization's established minimum requirements; 3) carries out the review, assessment, and validation as outlined in the organization's description of the process.	Subchapter II - Credentialing and Privileging: This subchapter describes the requirements for credentialing and privileging of health care professionals to provide patient care in an accreditable organization.	Number of credential files reviewed during the survey:	Description of how records were selected:	The medical staff must be accountable to the governing body. The governing body establishes and is responsible for a credentialing and reappointment process, applying criteria in a uniform manner to appoint individuals to provide patient care for the organization. The governing body approves mechanisms for credentialing, reappointment, and the granting of privileges, and suspending or terminating clinical privileges, including provisions for appeal of such decisions.	The governing body, either directly or by delegation, makes (in a manner consistent with state law) initial appointment, reappointment and assignment or curtailment of clinical privileges of medical staff members based on professional peer evaluation. This process shall have the following characteristics:	The governing body has specific criteria for the initial appointment and reappointment of physicians and dentists.	Provisions are made for the expeditious processing of applications for
2 - Governa	CMS								
Chapter 2	Standard					4	ω.	B-1	B-2

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	clinical privileges.		
B-3	On an application for initial credentialing and privileges, the applicant is required to provide sufficient evidence of training, experience, and current documented competence in performance of the procedures for which privileges are requested. At a minimum, the following credentialing and privileging information shall be provided for evaluation of the candidate:	sc	Verification of qualifications to include education and training is confirmed prior to the Board granting privileges. These requirements were verified by the surveyor in the credential files reviewed.
B-3a	Education, training and experience: Relevant education and training are verified at the time of appointment and initial granting of clinical privileges; the applicant's experience is reviewed for continuity, relevance and documentation of any interruptions in that experience	sc	
B-3b	Peer evaluation: Current competence is verified and documented	SC	Ongoing peer review is done and is part of the re-appointment process at this center.
B-3c	Current state license: Current licensure is verified and documented at the time of appointment	SC	All files had current Tennessee licenses.
B-3d	Drug Enforcement Administration (DEA) registration, if applicable	sc	DEA registrations were all current in files reviewed.
B-3e	Proof of current medical liability coverage meeting governing body requirements, if any	sc	All files had evidence of current endorsements for medical malpractice insurance.
B-3f	Information obtained from the National Practitioner Data Bank Note: The NPDB Proactive Disclosure Services (PDS) is an acceptable service for meeting the requirement for querying the NPDB.	sc	NPDB information was present in each file.
B-3g	The organization shall require and review other pertinent information which includes, but need not be limited to:	SC	This pertinent credentialing information was found in each credential file reviewed.
B-3g-i	Professional liability claims history	sc	
B-3g-ii	Information on licensure revocation, suspension, voluntary relinquishment, licensure probationary status, or other licensure conditions or limitations	SC	
B-3g-iii	Complaints or adverse action reports filed against the applicant with a local, state, or national professional society or licensure board	SC	
B-3g-iv	Refusal or cancellation of professional liability coverage	sc	
B-3g-v	Denial, suspension, limitation, termination or nonrenewal of professional privileges at any hospital, health plan, medical group, or other health care entity	SC	
B-3g-vi	DEA and state license action	SC	

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B-3g-vii	Disclosure of any Medicare/Medicaid sanctions	SC	An OIG search is done.
B-3g-viii	Conviction of a criminal offense (other than minor traffic violations)	sc	
В-3g-іх	Current physical, mental health, or chemical dependency problems that would interfere with an applicant's ability to provide high-quality patient care and professional services	it sc	
B-3g-x	Signed statement releasing the organization from liability and attesting to the correctness and completeness of the submitted information	to SC	
P8 4	Upon completion of the application, the credentials are verified according to procedures established in the organization's bylaws, rules and regulations or policies. The organization has established procedures to obtain information necessary for primary or secondary source verification of the credentials and is responsible for obtaining this information. An accreditable organization may use information provided by a Credentials Verification Organization may use information provided by a Credentials Verification organization may be complete proper assessment of the capability and quality by becoming accredited or certified by a nationally recognized accreditation organization.  Primary or acceptable secondary source verification is required for items listed in 2.II. 8-3a-f, unless a CVO or an organization performing primary source verification that its accredited or certified by a nationally recognized body is used. If the organization utilizes a CVO or another organization to verify credentials, those entities must perform primary source verification unless such sources do not exist or are impossible to verify.	on on lifty lifty lifty on	The organization uses primary and secondary sources for verification of all application information.
B-5	Medical staff must apply for reappointment every three (3) years, or more frequently if state law or organizational policies so stipulate. At reappointment, the organization requires completion of a reappointment application and verifies items listed in Standard 2.II.B-3c-g and peer review activities as described in Subchapter I of Chapter 5.	ore SC	Staff appointment is every two years. Peer review is done and is considered as part of reappointment of all providers.
B-6	The organization shall monitor and document current licensure, professional liability insurance if required, certifications, DEA and other registrations, where applicable, on an ongoing basis.	SS	The Center Administrator and AmSurg Corporate Office Staff have a process in place to monitor all required documents as part of the appointment term.
P-7	In a solo medical or dental practice, the provider's credentials file shall be reviewed by an outside physician (for a medical practice) or an outside dentist (for a dental practice) at least every three (3) years, or more frequently, if state law or organizational policies so stipulate, to ensure currency, accuracy and completeness of his/her credentials. The provider is required to complete an application or reapplication, and the documentation identified in Standard 2.II.B-3 must be present in the credentials file, including a list of procedures that will be performed by the provider in the organization practice setting and evidence of appropriate education, training, and experience to perform the privileged procedures. Applications are available for other providers requesting credentialing and	the tree es.	

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notivileges to perform procedures in the solo provider's organization, notiding any anesthesia providers. In a solo provider's practice, the granting of privileges shall be reviewed by an outside physician (for medical practices) or dentist (for dental practices).  Privileging is a three-phase process. The objective of privileging is determine the specific procedures and treatments that a health care professional may perform. An accreditable organization: 1) determines the qualifications related to training and experience that required to authorize an applicant to obtain each privilege; and 3) establishes a process for evaluating the applicant's qualifications us appropriate criteria and approving, modifying or denying any or all of requested privileges in a non-arbitrary manner.  The scope of procedures must be periodically reviewed by the gover body and amended as appropriate.  Privileges to carry out specified procedures are granted by the organization to the health care professional to practice for a specifie pendod fitme. These privileges are granted based on an applicant qualifications within the services provided by the organization and recommendations from qualification endical personnel.  Mechanisms are in place for the organization to notify licensing and disciplinary bodies or other appropriate authorities, including the NP winner a medical staff member's privileges are supremed or termina requires review and approved loy the organization to provileges granted, solely on the significations with an expensive and approved to organization, such as a hospital, approved creden organization may be included in the governing body's consideration application.  The governing body provides a process (in a manner consistent with the amended privileges, without further review. Such status at another organization may be included in the governing body's consideration curtailment of privileges and practice for allied health care profession curtailment of privileges and practice for allied health care profession.		to nines are are the control of the	ming SC There is an approved privilege list approved by the Operating Board.	SC Privileges for each provider is granted for a specified period of time. However, the file does not specify a start and end date.	or SC DB, led, as	and SC he he htals of the	SC This organization, at the present time, only credentials GI physicians and CRNAs.  CRNAs.  CRNAs.	Suggest the Operating Board develop a management succession plan for
	privileges to perform procedures in the solo provider's organization, including any anesthesia providers. In a solo provider's practice, the granting of privileges shall be reviewed by an outside physician (for medical practices) or dentist (for dental practices).	Privileging is a three-phase process. The objective of privileging is to determine the specific procedures and treatments that a health care professional may perform. An accreditable organization: 1) determines the clinical procedures and treatments that are offered to patients; 2) determines the qualifications related to training and experience that are required to authorize an applicant to obtain each privilege; and 3) establishes a process for evaluating the applicant's qualifications using appropriate criteria and approving, modifying or denying any or all of the requested privileges in a non-arbitrary manner.	The scope of procedures must be periodically reviewed by the governing body and amended as appropriate.	Privileges to carry out specified procedures are granted by the organization to the health care professional to practice for a specified period of time. These privileges are granted based on an applicant's qualifications within the services provided by the organization and recommendations from qualified medical personnel.	Mechanisms are in place for the organization to notify licensing and/or disciplinary bodies or other appropriate authorities, including the NPDB, when a medical staff member's privileges are suspended or terminated, as required by state or federal law and regulations.	The organization has its own independent process of credentialing and privileging. The approval of credentials or the granting of privileges requires review and approval by the organization's governing body. Credentials may not be approved, nor privileges granted, solely on the basis that another organization, such as a hospital, approved credentials or granted privileges, without further review. Such status at another organization may be included in the governing body's consideration of the application.	The governing body provides a process (in a manner consistent with state law and based on evidence of education, training, experience, and current competence) for the initial appointment, reappointment and assignment or curtailment of privileges and practice for allied health care professionals.	Consultative Comments

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Chapter	Chapter 3 - Administration	ration		The second second
Standard	CMS		Compliance Rating	Comments
		An accreditable organization is administered in a manner that assures the provision of high-quality health services and that fulfills the organization's mission, goals and objectives. Such an organization has the following characteristics.		
ı		Overall Chapter Compliance Level	SC	Corporate policies and procedures governing The Endoscopy Center's operations were in place and available for review. Initial training and orientation were conducted in a timely manner when staff were hired and annually thereafter.
		Number of personnel files reviewed during the survey:	9	
		Description of how records were selected:		Personnel records were selected from all three locations and a variety of skill sets.
		An accreditable organization is administered in a manner that ensures the provision of high-quality health services and that fulfills the organization's mission, goals and objectives. Such an organization has the following characteristics.		
⋖		Administrative policies, procedures and controls are established and implemented to ensure the orderly and efficient management of the organization. Administrative responsibilities include, but are not limited to:	SC	
A-1		Enforcing policies delegated by the governing body	SC	
A-2		Employing qualified management personnel	SC	
A-3		Long-range and short-range planning for the needs of the organization, as determined by the governing body	SS	Priorities of the organization were evident and supported the direction established by the governing body. Resources were dedicated to ensure the successful accomplishment of the governing body's goals.
A 4		Taking all reasonable steps to comply with applicable laws and regulations	SC	
A-5		Protecting the assets of the organization	SC	
A-6		Implementing fiscal controls, including, but not limited to:	SC	
A-6a		Authorization and record procedures that are adequate to provide	SC	

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	accounting controls over assets, liabilities, revenues and expenses		
A-6b	Policies and procedures for controlling accounts receivable and accounts payable and for handling cash and credit arrangements	SC	
A-6c	Rates and charges for services provided by the organization	SC	Rates and charges of services were established and updates of any changes were provided to the board for their approval and engagement.
A-6d	Methods of collection of unpaid accounts that are reviewed before referral to a collection agency	SC	
A-7	Using methods of communicating and reporting designed to ensure the orderly flow of information within the organization	SC	
A-8	Controlling the purchase, maintenance and distribution of the equipment, materials and facilities of the organization	SC	
A-9	Establishing lines of authority, accountability and supervision of personnel	SS	The organization had developed a clear organizational structure that provided information on lines of authority and accountability for effective center operations.
A-10	Establishing controls relating to the custody of the official documents of the organization	SC	
A-11	Maintaining the confidentiality, security and physical safety of data on patients and staff	SC	The organization maintains patient and staff information on comprehensive information management systems. Each system ensures security through physical and password controls to ensure confidentiality of information.
A-12	Maintaining a health information system that collects, integrates, analyzes and reports data as necessary to meet the needs of the organization	SC	
A-12a	Characteristics of the system should include, but are not limited to:	SC	The organization maintains an electronic record that is available and used at all three operating locations. The information system enhances the peer review process and ensures patient information is available during any quality improvement initiatives.
A-12a-i	Linkage between the quality improvement program to meet performance improvement/quality indicators and quality improvement activities	SC	
A-12a-ii	Ensuring accurate, timely and complete data in a consistent manner as appropriate for the organization	သွ	
A-12a-iii	Maintaining collected data in a standardized format to the extent feasible and appropriate	SC	
A-13	Addressing the relationships with competing health care organizations to	SC	The organization is the primary stand alone endoscopy center in the

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	avoid antitrust and restraint of trade concerns		Knoxville market. Coordination and communication efforts with their referring organizations and customers ensure they are meeting their patient's needs. The Operating Board would address any relationships with competing organizations.
A-14	Dealing with inquiries from governmental agencies, attomeys, consumer advocate groups, reporters and the media	SC	
ш	Personnel policies are established and implemented to facilitate attainment of the mission, goals, and objectives of the organization. Personnel policies:	sc	Clear personnel policies ensure staff members are aware of their responsibilities and roles within the organization. All staff are trained upon initial hire and through annual training programs.
B-1	Define and delineate functional responsibilities and authority	SC	
B-2	Require the employment of personnel with qualifications commensurate with job responsibilities and authority, including appropriate licensure or certification	SS	Excellent staff morale and lengthy tenure ensure programs and processes are executed in line with the organization's goals and objectives.
B-3	Reflect the requirement for documentation of initial orientation and training according to position description. Initial orientation and training shall be:	SC	
B-3a	Completed within 30 days of commencement of employment	SC	The Endoscopy Center ensures all staff members receive initial orientation to the organization and are instructed on all required topics.
B-3b	Provided annually thereafter and when there is an identified need	sc	
B-3c	Provided by a qualified person(s) designated by the organization	SC	
B-4	Require periodic appraisal of each person's job performance, including current competence	S	While all employees had received annual appraisals during their tenure, not all employees had timely appraisals available for review in the employee personnel files, One appraisal was from 2007 and another from 2009.
B-5	Describe incentives and rewards, if any exist	sc	
B-6	Require periodic review of employee compensation	SC	The employee compensation review process was managed by the CFO.
B-7	Specify privileges and responsibilities of employment, including compliance with an adverse incident reporting system, as described in Standard 2.1.B-21	SC	
B-8	Are made known to employees at the time of employment	SC	
B-9	Comply with federal and state laws and regulations regarding verification of eligibility for employment, such as I-9 (Immigration and Naturalization form) and visas, as required	SC	All personnel files reviewed contained a completed 1-9 and included background checks, certifications and continuing education credits.

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C-1         In complian           C-2         Reviewed availability           C-3         Made a pain availability           D-1         Heatth carrest ede           D-1a         An effective           D-1b         Exposure of exposures           D-1c         Post-expos           D-1d         Appropriat           D-1e         Appropriat           D-1e         Appropriat           D-2         An immunity	In compliance with current OSHA bloodborne pathogen regulations  Reviewed and undated at least annually including an evaluation for the		updated when changes are required.
		sc	
		SC	
	Made a part of employee initial orientation and annual retraining	SC	
	Health care workers are protected from biologic hazards, consistent with state, federal and CDC guidelines through:	SC	
	An effective program addressing bloodborne pathogens including:	SC	
	Exposure control plan designed to eliminate or minimize employee exposures	SC	
	Hepatitis B vaccination program	SC	Employees were offered the opportunity to receive Hepatitis B vaccination and declaration forms were present in all employees folders.
	Post-exposure evaluation and treatment	SC	
	Appropriate training in and communication of hazards to employees	SC	All employees received initial training and orientation to the organization. The training ensured staff members were aware of hazards associated with the position.
	Appropriate record keeping and management.	SC	
	An immunization program for other infectious agents of risk to health care workers and their patients	SC	
D-3 A tuberou	A tuberculosis respiratory protection program	SC	Initial tuberculosis screening occurred when starting employment and then again one week later to ensure complete test results.
D-4 Programs bioternoris	Programs addressing other relevant biological hazards, such as bioterrorism, as needed for employee safety and health.	SC	
A progran occupatio	A program is maintained to assess and reduce risks associated with occupational chemical exposures, including:	SC	Appropriate personal protective equipment was available and used at all three operating locations. MSDS were available at the main location in the administrator's office and staff was aware of the information's location.
E-1 Hazard as	Hazard assessment of chemicals used in the workplace	SC	
E-2 Engineeri	Engineering measures to reduce the risk of chemical exposure	SC	

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E-3	Worker training programs	SC	
LL	A program is maintained to assess, and where necessary, reduce risks associated with physical hazards, such as, ergonomic exposures, violence at the workplace and external physical threats such as terrorism.	SC	Policies are available for staff to manage risks in the workplace.
g	Records of work injuries or illnesses are maintained, consistent with reporting requirements, and employee health records are managed appropriately.	SC	
I	The organization periodically assesses patient satisfaction with services and facilities provided by the organization. The findings are reviewed by the governing body and, when appropriate, corrective actions are taken.	SC	The organization has established a comprehensive patient satisfaction survey for each of their locations. Satisfaction was excellent for each of their operating locations.
	When students and postgraduate trainees are present, their status is defined in the organization's personnel policies.	NA	
	Consultative Comments		Consultative Comments  Continue to review corporate policies to ensure specific details are applicable to The Endoscopy Center and the unique geographic location and customer population. Consider adding a declarative statement concerning flu shots for employees.

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Standard   Cube   An accorditable organization provides high-quality health care in an additionable of professional provides thigh-quality health care in importance with the principles of professional protestional protestion	Chapter	4 - Quality of	Chapter 4 - Quality of Care Provided		
An accreditable organization provides high-quality health care and ethical conduct, and with concern for the costs of care and for improving the community's health status. Such an organization has the following characteristics.  Overall Chapter Compliance Level  All health care professionals have the necessary and appropriate training and skills to deliver the services provided by the organization.  Health care professionals practice their professions in an ethical and legal manner.  All personnel assisting in the provision of health care services are appropriately trained, qualified and supervised and are available in sufficient numbers for the care provided.  The organization, with active participation of the medical staff must conduct an orgonig, comprehensive self-assessment of the quality of care provided as described in Subcripate in 10 Chapter 8, and consideration of clinical privileges as described in Subcribate in 10 Chapter 2 and clinical privileges as described in Subcribate in 10 Chapter 2 and consideration of clinical privileges as described in Subcribate in 10 Chapter 2 and consideration of Subcripated by the following:  Health care provided is consistent with current professional knowledge clinical privileges as described in Subcribate in 10 Chapter 2 and consideration of Subcripated of an effective communication with, those served concerning the diagnosis and treatment of their conditions, appropriate preventive measures and use of the health care system and physical examination  Appropriate examination  Review and update of all individual patient medications at each visit,	Standard	CMS		Compliance Rating	Comments
All health care professionals have the necessary and appropriate training and skills to deliver the services provided by the organization.  Health care professionals practice their professions in an ethical and legal manner.  All personnel assisting in the provision of health care services are appropriately trained, qualified and supervised and are available in sufficient numbers for the care provided.  All personnel assisting in the provision of health care services are appropriately trained, qualified and supervised and are available in sufficient numbers for the care provided.  The organization, with active participation of the medical staff must conduct an ongoing, comprehensive self-assessment of the quality of care provided as described in Subchapter I of Chapter 2, including medical necessity of care or procedures personned and appropriate rates of care, and use findings, when appropriate in the evision of the organization of clinical privileges as described in Subchapter I of Chapter 2 and consideration of clinical privileges as described in Subchapter I of Chapter 2 and consideration of clinical privileges as described in Subchapter I of Chapter 2 and consideration of clinical privileges as described in Subchapter I of Chapter 2 and consideration of and effective communication with, those served concerning the delignosis and treatment of their conditions, appropriate preventive measures and use of the health care system  Appropriate and timely diagnosis based on findings of the current history and physical examination  Subchapter I all individual patient medications at each visit, SC			provides high the principles h concern for t health status.		
All health care professionals have the necessary and appropriate training and skills to deliver the services provided by the organization.  Health care professionals practice their professions in an ethical and legal superportately trained, qualified and supervised and are available in sufficient numbers for the care provided.  The organization, with active participation of the medical staff, must conduct an organization, with active participation of the medical staff, must conduct an organization, with active participation of the organization of necessity of care provided.  The organization, which active participation of the organization of necessity of care provided as described in Subchapter II of Chapter 2 and consideration of clinical privileges as described in Subchapter II of Chapter 2 and consideration of clinical privileges as described in Subchapter II of Chapter 2 and consideration of clinical privileges as described in Subchapter II of Chapter 2 and subchapter I of Chapter 6.  The organization facilitates the provision of high-quality health care as demonstrated by the following:  Health care provided is consistent with current professional knowledge  Education of, and effective communication with, those served concerning the diagnosis and treatment of their conditions, appropriate preventive measures and use of the health care system  Review and update of all individual patient medications at each visit,			Overall Chapter Compliance Level	SC	
Health care professionals practice their professions in an ethical and legal manner.  All personnel assisting in the provision of health care services are appropriately trained, qualified and supervised and are available in sufficient numbers for the care provided.  The organization, with active participation of the medical staff, must conduct an ongoing, comprehensive self-assessment of the quality of care provided as described in Subchapter I of Chapter 2, including medical necessity of care or procedures performed and appropriateness of care, and use findings, when appropriate in the revision of the organization policies as described in Subchapter I of Chapter 2 and consideration of clinical privileges as described in Subchapter I of Chapter 2 and consideration of clinical privileges as described in Subchapter I of Chapter 2 and consideration of clinical privileges as described in Subchapter I of Chapter 2 and consideration of clinical privileges as described in Subchapter I of Chapter 2 and consistent Anothapter I of Chapter 2 and consistent with current professional knowledge SC demonstrated by the following:  Health care provided is consistent with current professional knowledge SC the demonstrated by the following:  Education of, and effective communication with, those served concerning the diagnosis and treatment of their conditions, appropriate preventive measures and use of the health care system  Appropriate and timely diagnosis based on findings of the current history and physical examination.	∢		All health care professionals have the necessary and appropriate training and skills to deliver the services provided by the organization.	SC	Observation and review of all administrative and credential files confirms quality healthcare professionals providing endoscopy services at all locations.
All personnel assisting in the provision of health care services are appropriately trained, qualified and supervised and are available in sufficient numbers for the care provided.  The organization, with active participation of the medical staff, must conduct an ongoing, comprehensive self-assessment of the quality of care provided as described in Subchapter I of Chapter 5, including medical necessity of care or procedures performed and appropriateness of care, and use findings, when appropriate, in the revision of the organization of clinical privileges as described in Subchapter I of Chapter 2 and consideration of clinical privileges as described in Subchapter I of Chapter 2 and Subchapter I of Chapter 5.  The organization facilitates the provision of high-quality health care as 4.  Health care provided is consistent with current professional knowledge SC demonstrated by the following:  Health care provided is consistent with current professional knowledge SC demonstrated by the following:  Appropriate and use of the health care system  Appropriate eard timely diagnosis based on findings of the current history and physical examination  Review and update of all individual patient medications at each visit, SC	ω		Health care professionals practice their professions in an ethical and legal manner.	SC	All endoscopists are board certified by the American Board of Medical Specialties.
The organization, with active participation of the medical staff, must conduct an ongoing, comprehensive self-assessment of the quality of care provided as described in Subchapter II of Chapter 5, including medical necessity of care or procedures performed and appropriateness of care, and use findings, when appropriate, in the revision of the organization policies as described in Subchapter I of Chapter 2 and Subchapter I of Chapter 5.  The organization facilitates the provision of high-quality health care as demonstrated by the following:  Health care provided is consistent with current professional knowledge SC demonstrated by the following:  Education of, and effective communication with, those served concerning the diagnosis and treatment of their conditions, appropriate preventive measures and use of the health care system  Appropriate and timely diagnosis based on findings of the current history and physical examination  Review and update of all individual patient medications at each visit, SC	O		All personnel assisting in the provision of health care services are appropriately trained, qualified and supervised and are available in sufficient numbers for the care provided.	သွ	A review of job descriptions and observation of staff in all locations confirms appropriate staffing pattern for the volume of procedures performed at each location.
The organization facilitates the provision of high-quality health care as demonstrated by the following:  Health care provided is consistent with current professional knowledge SC Education of, and effective communication with, those served concerning the diagnosis and treatment of their conditions, appropriate preventive measures and use of the health care system  Appropriate and timely diagnosis based on findings of the current history and physical examination  Review and update of all individual patient medications at each visit, SC	Q		The organization, with active participation of the medical staff, must conduct an ongoing, comprehensive self-assessment of the quality of care provided as described in Subchapter II of Chapter 5, including medical necessity of care or procedures performed and appropriateness of care, and use findings, when appropriate, in the revision of the organization policies as described in Subchapter I of Chapter 2 and consideration of clinical privileges as described in Subchapter II of Chapter 2 and Subchapter I of Chapter 2 and	SS	This organization has a comprehensive quality assurance/process improvement program in place with support and guidance from AmSurg Corporation. All credentialed practitioners are properly vetted per policies and procedures approved by the operating board. Peer review is part of the reappointment process which was documented in each physician and CRNA file.
Health care provided is consistent with current professional knowledge SC Education of, and effective communication with, those served concerning the diagnosis and treatment of their conditions, appropriate preventive measures and use of the health care system  Appropriate and timely diagnosis based on findings of the current history and physical examination  Review and update of all individual patient medications at each visit, SC	ш		The organization facilitates the provision of high-quality health care as demonstrated by the following:	SC	
Education of, and effective communication with, those served concerning the diagnosis and treatment of their conditions, appropriate preventive measures and use of the health care system  Appropriate and timely diagnosis based on findings of the current history and physical examination  Review and update of all individual patient medications at each visit,	7		Health care provided is consistent with current professional knowledge	SC	All staff provide consistent health care services.
Appropriate and timely diagnosis based on findings of the current history and physical examination  Review and update of all individual patient medications at each visit, SC	E-2		Education of, and effective communication with, those served concerning the diagnosis and treatment of their conditions, appropriate preventive measures and use of the health care system	SC	
Review and update of all individual patient medications at each visit,	E-3		Appropriate and timely diagnosis based on findings of the current history and physical examination	SC	
	4 H		Review and update of all individual patient medications at each visit,	SC	All patient medical record information was current in each record

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	including over-the-counter products and dietary supplements when information is available		reviewed.
E-5	Treatment that is consistent with clinical impression or working diagnosis	sc	
E-6	Appropriate and timely consultation	SC	There is a letter to the referring physician regarding any patient that undergoes an evaluation and procedure by a physician at this center.
E-7	Absence of clinically unnecessary diagnostic or therapeutic procedures	sc	
E-8	Appropriate and timely referrals	SC	
E-9	Appropriate and timely follow-up of findings and tests	SC	See E-9
E-10	Patient participation	SC	
E-11	Continuity of care and patient follow-up	sc	See E-6
E-12	Patient satisfaction	SC	Patient satisfaction is queried and generated by Health Stream and are specific to each location. Areas for improvement are reviewed and discussed with the quality committee and reported to the governing board.
L	The organization provides for accessible and available health services and ensures patient safety by at least the following:	SC	
F-T	Provision for and information about services when the organization's facilities are not open	SC	All patients are provided information regarding how to obtain services after hours as part of the patient discharge instructions.
F-2	Adequate and timely transfer of information when patients are transferred to other health care professionals	SC	
F-3	An increased likelihood of desired health outcomes through participation in performance measurement and quality improvement activities	SC	The medical director and the physicians have set up goals for improvement in several areas in partnership with a Blue Cross/Blue Shield contract.
4	An adverse incident reporting system, as described in Standard 2.1.B-21	SC	The center uses the AmSurg reporting guidelines. All incidents are reported to the OR committee, governing body and AmSurg corporate office.
٦. ت	A mechanism to notify public health authorities of reportable conditions	SC	There is a policy in place to report communicable diseases to the department of health.
Ø	The organization maintains appropriate, accurate and complete and timely clinical record entries.	SC	The center utilizes an electronic medical record, that is current and complete.
I	The organization establishes procedures to obtain, identify, store and transport laboratory specimens or biological products.	SC	Policies and procedures are in place for the management of all specimens. Proper collection boxes are present at all locations.

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J-1     Adequate specialty consultation services being available by prior arrangement.     SC       J-2     Referral to a health care professional that is clearly outlined to the patient and arrangement.     SC       K-1     When hospitalization is indicated to evaluate stabilize and transfer when engencies or unplanned outcomes occur, the organization shall have one of the following.     SC       K-1     Whiten transfer agreement for transferring patients to a nearty hospital     SC       K-2     Policy of oredentialing and privileging only physicians and dentists who have admitting and similar privileges at a nearby hospital     SC       K-3     Detailed procedural plan for handling medical emergencies, with the plan     NA       K-3     Detailed procedural plan for handling medical emergencies, with the plan     SC       L-1     The relevance of health care services to the needs of the patients     SC       L-2     The absence of duplicative diagnostic procedures     SC       L-3     The absence of duplicative diagnostic procedures     SC       L-4     The use of the least expensive alternate resources when suitable     SC       M     When the need arises, reasonable attempts are made for health care     SC       L-5     The use of the least expensive alternate resources when suitable or manning and private agains and deters in the language or manner	When clinically indicated, patients are contacted as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings that have been identified.	sc	Patients are immediately notified via mail and/or telephone regarding results of all tissue specimens (normal and abnormal).
Adequate specialty consultation services being available by prior arrangement  Referral to a health care professional that is clearly outlined to the patient and arranged with the accepting health care professional prior to transfer when one of the following:  When hospitalization is indicated to evaluate, stabilize and transfer when one of the following:  Written transfer agreement for transferring patients to a nearby hospital  SC  Written transfer agreement for transferring patients to a nearby hospital  Policy of credentialing and privileging only physicians and dentists who have admitting and similar privilegors at a nearby hospital  Concern for the costs of care is demonstrated by the following:  The relevance of health care services to the needs of the patients  The absence of duplicative diagnostic procedures  The use of ancillary services that are consistent with patients' needs  When the need arises, reasonable attempts are made for health care professionals and other staff to communicate in the language or manner primarity used by patients.	ansferred from the care of one health	SC	
Referral to a health care professional that is clearly outlined to the patient and arranged with the accepting health care professional prior to transfer when one of the following:  When hospitalization is indicated to evaluate, stabilize and transfer when one of the following:  Written transfer agreement for transferring patients to a nearby hospital soc one of the following:  Policy of credentialing and privileging only physicians and dentists who have admitting and similar privileges at a nearby hospital  Detailed procedural plan for handling medical emergencies, with the plan submitted to AAAHC for review during the survey process  Concern for the costs of care is demonstrated by the following:  The relevance of health care services to the needs of the patients  The absence of duplicative diagnostic procedures  The use of the least expensive alternate resources when suitable  SC  The use of ancillary services that are consistent with patients' needs  When the need arises, reasonable attempts are made for health care professionals and other staff to communicate in the language or manner primarily used by patients.	ices being available by prior	SC	
When hospitalization is indicated to evaluate, stabilize and transfer when annegencies or unplanned outcomes occur, the organization shall have one of the following:  Written transfer agreement for transferring patients to a nearby hospital  Policy of credentialing and privileging only physicians and dentists who have admitting and similar privileges at a nearby hospital  Detailed procedural plan for handling medical emergencies, with the plan NA submitted to AAAHC for review during the survey process.  Concern for the costs of care is demonstrated by the following:  The relevance of health care services to the needs of the patients  The absence of duplicative diagnostic procedures  The absence of duplicative diagnostic procedures  The use of the least expensive alternate resources when suitable  The use of ancillary services that are consistent with patients' needs  When the need arises, reasonable attempts are made for health care professionals and other staff to communicate in the language or manner primarily used by patients.	that is clearly outlined to the patient th care professional prior to transfer	sc	
Written transfer agreement for transferring patients to a nearby hospital Policy of credentialing and privileging only physicians and dentists who have admitting and similar privileges at a nearby hospital Detailed procedural plan for handling medical emergencies, with the plan Submitted to AAAHC for review during the survey process Concern for the costs of care is demonstrated by the following:  The relevance of health care services to the needs of the patients SC The absence of duplicative diagnostic procedures The absence of duplicative diagnostic procedures The use of the least expensive alternate resources when suitable SC The use of ancillary services that are consistent with patients' needs SC When the need arises, reasonable attempts are made for health care professionals and other staff to communicate in the language or manner primarily used by patients.  Consultative Comments	valuate, stabilize and transfer when cocur, the organization shall have	sc	
Policy of credentialing and privileges at a nearby hospital have admitting and similar privileges at a nearby nospital  Detailed procedural plan for handling medical emergencies, with the plan submitted to AAAHC for review during the survey process  Concern for the costs of care is demonstrated by the following:  The relevance of health care services to the needs of the patients  The absence of duplicative diagnostic procedures  The absence of duplicative diagnostic procedures  The appropriateness of treatment frequency  The use of the least expensive alternate resources when suitable  SC  The use of ancillary services that are consistent with patients' needs  When the need arises, reasonable attempts are made for health care professionals and other staff to communicate in the language or manner primarily used by patients.  Consultative Comments	erring patients to a nearby hospital	sc	There is a transfer agreement in place with Physicians Regional Medical Center (formerly known as Mercy Hospital)
Detailed procedural plan for handling medical emergencies, with the plan submitted to AAAHC for review during the survey process.  Concern for the costs of care is demonstrated by the following:  The relevance of health care services to the needs of the patients  The absence of duplicative diagnostic procedures  The absence of duplicative diagnostic procedures  The appropriateness of treatment frequency  The use of the least expensive alternate resources when suitable  SC  The use of ancillary services that are consistent with patients' needs  When the need arises, reasonable attempts are made for health care professionals and other staff to communicate in the language or manner primanly used by patients.  Consultative Comments	only physicians and dentists who at a nearby hospital	sc	All endoscopists are privileged at the local hospital
Concern for the costs of care is demonstrated by the following:  The relevance of health care services to the needs of the patients  The absence of duplicative diagnostic procedures  The appropriateness of treatment frequency  The use of the least expensive alternate resources when suitable  The use of ancillary services that are consistent with patients' needs  When the need arises, reasonable attempts are made for health care professionals and other staff to communicate in the language or manner primarily used by patients.  Consultative Comments	medical emergencies, with the plan g the survey process	NA	
The relevance of health care services to the needs of the patients SC  The absence of duplicative diagnostic procedures SC  The appropriateness of treatment frequency SC  The use of the least expensive alternate resources when suitable SC  The use of ancillary services that are consistent with patients' needs SC  When the need arises, reasonable attempts are made for health care professionals and other staff to communicate in the language or manner primarily used by patients.	onstrated by the following:	SC	The AmSurg management team reviews monthly financial data which reflects the cost of care for different procedures.
The absence of duplicative diagnostic procedures SC  The appropriateness of treatment frequency  The use of the least expensive alternate resources when suitable SC  The use of ancillary services that are consistent with patients' needs  When the need arises, reasonable attempts are made for health care professionals and other staff to communicate in the language or manner primarily used by patients.  Consultative Comments	s to the needs of the patients	SC	
The use of the least expensive alternate resources when suitable SC  The use of ancillary services that are consistent with patients' needs  When the need arises, reasonable attempts are made for health care professionals and other staff to communicate in the language or manner primarily used by patients.  Consultative Comments	c procedures	sc	
The use of the least expensive alternate resources when suitable SC  The use of ancillary services that are consistent with patients' needs SC  When the need arises, reasonable attempts are made for health care professionals and other staff to communicate in the language or manner primarily used by patients.  Consultative Comments	quency	sc	
The use of ancillary services that are consistent with patients' needs SC  When the need arises, reasonable attempts are made for health care professionals and other staff to communicate in the language or manner primarily used by patients.  Consultative Comments	ate resources when suitable	sc	
When the need arises, reasonable attempts are made for health care professionals and other staff to communicate in the language or manner primarily used by patients.  Consultative Comments	consistent with patients' needs	sc	
	tempts are made for health care nunicate in the language or manner	SC	The center utilizes a local interpreting company (foreign language academy) when indicated to support patient and family members who do not speak English. The center also uses a local company for sign language for the hearing impaired patient.
			Consultative Comments

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		Peer review is documented in each provider file and is reported to the Operating Board.	Peer review activities are included as part of the re-credentialing process.				This required monitoring activity is managed by the management team.	Consultative Comments
SC	SC	SC	sc	SC	SC	SC	SC	
Health care professionals participate in the development and application of the criteria used to evaluate the care they provide.	Data related to established criteria are collected in an ongoing manner and are periodically evaluated to identify acceptable trends or occurrences that affect patient outcomes.	The results of peer review activities are reported to the governing body.	The results of peer review are used as part of the process for granting continuation of clinical privileges, as described in Subchapter II of Chapter 2.	To improve the professional competence and skill, as well as the quality of performance, of the health care professionals and other professional personnel it employs, the organization:	Provides convenient access to reliable, up-to-date information pertinent to the clinical, educational, administrative and research services provided by the organization	Encourages health care professionals to participate in educational programs and activities, as demonstrated in the organization's policies or procedures; these educational programs may be internal or external, and are consistent with the organization's mission, goals, and objectives	The organization provides a monitoring function to ensure the continued maintenance of licensure and/or certification of professional personnel who provide health care services at the organization.	Consultative Comments
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Chapter	5 - Quality M	Chapter 5 - Quality Management and Improvement - Quality Improvement Program II	ent Progr	am II
Standard	CMS		Compliance Rating	Comments
		Subchapter II - Quality Improvement Program: An accreditable organization maintains an active, integrated, organized, and peer-based quality improvement (QI) program as evidenced by the following characteristics:	SC	
4		The organization develops and implements a quality improvement program that is broad in scope to address clinical, administrative, and cost-of-care performance issues, as well as actual patient outcomes, i.e., results of care, including safety of patients. Characteristics of the written program must include, but are not limited to:	SC	The center has adopted the QAPI Program developed by AmSurg.
A-1		A description of the program that addresses the scope of the organization's health care delivery services and how the quality improvement plan for these services is assessed	SC	
A-2		Identification of the specific committee(s) or individuals responsible for the development, implementation and oversight of the program	SC	There is a QAPI Committee which meets each quarter.
A-3		Participation in the program by health care professionals, one or more of whom is a physician	sc	Physicians participate in the QAPI program.
A-4		Quality improvement goals and objectives	sc	Goals and objectives are clearly stated in the QAPI program.
A-5		Development of processes to identify important problems or concems that are appropriate to address for improving the quality of services provided by the organization	SC	
A-6		Identification of quality improvement activities such as studies, including methods for performing internal and external benchmarking to support the goals of the program.	SC	QI studies have come from benchmarking activities at this center.
A-7		Defined linkages between quality improvement activities, peer review and the risk management program	SC	Linkages are defined in the QAPI plan and is reflected in their QAPI committee minutes and the Operating Board minutes.
A-8		Evaluation of the overall effectiveness of the program at least annually	SC	The QAPI program is evaluated each year by the QAPI Committee and the Operating Board.
A-9		Identification of processes to report findings from the quality improvement activities to the organization's governing body, and throughout the organization, as appropriate	SC	

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The organization conducts specific quality improvement activities that support the goals of the written QI program. Written reports of QI activities must demonstrate that each activity includes at least the following elements:	SS	The center uses the AAAHC Ten Step process in conducting a QI study.
A statement of the purpose of the QI activity that includes a description of the process or situation being reviewed, or a known or suspected problem, and explains why it is significant to the organization	SS	
Identification of the performance goal against which the organization will compare its current performance in the area of study	SC	
Description of the data that will be collected in order to determine the organization's current performance	SC	
Evidence of data collection	sc	
Data analysis that describes findings about the frequency, severity and source(s) of the problem(s)	sc	
A comparison of the organization's current performance in the area of study against the previously identified performance goal	sc	
Implementation of corrective action(s) to resolve identified problem(s)	SC	
Re-measurement (a second round of data collection and analysis as described in Standard 5.II.B-4-6) to objectively determine whether the corrective actions have achieved and sustained demonstrable improvement	SC	
If the initial corrective action(s) did not achieve and/or sustain the desired improved performance, implementation of additional corrective action(s) and continued re-measurement until the problem is resolved or is no longer relevant	SC	
Communication of the findings of the quality improvement activities to the governing body and throughout the organization, as appropriate, and incorporation of such findings into the organization's educational activities ("closing the QI loop")	SC	
The organization's written quality improvement program must include participation in external performance benchmarking activities that will allow for the comparison of key performance measures with other similar organizations or with recognized best practices of national or professional targets or goals.	SC	Internal and external benchmarking is done in this organization. Benchmarking information was available for surveyors to review.
The organization's benchmarking activities include, but are not limited to:	SC	

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C-1a	The use of selected performance measures that are appropriate for improving the processes or outcomes of care relevant to the patients served	SC	
C-1b	Systematically collecting and analyzing data related to the selected performance measures	SC	
C-1c	Ensuring the validity and reliability of data	sc	
C-1d	Measuring changes in performance related to the performance measures	SC	
C-1e	Demonstrating and sustaining performance improvement over time	SC	
C-1f	Using benchmarks that are based on local, state, or national standards, i.e., performance measures.	SC	This center benchmarks nationally with 18 other GI Centers of comparable size.
C-2	Results of benchmarking activities must be incorporated into other quality improvement activities of the organization.	SC	
£50	Results of benchmarking activities must be reported to the organization's governing body and throughout the organization, as appropriate.	SC	Benchmarking activities are reported to staff and the Operating Board.
11 722	Consultative Comments		Consultative Comments
			Suggest that the organization involve more staff in participating in a future QI Study.

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provement - Quality Improvement Studies IIa	Compliance Comments Rating			Patient Safety/Falls in The Endoscopy Center	des a description of SC Purpose of study and problem stated. Sc significant to the	le organization will	o determine the SC Data for 18 months of reported incident reported reviewed.	SC Data Collection Sheet used to support study analysis.	incy, severity and SC Data analysis done.	ce in the area of bal.	ified problem(s).	round of data collection and analysis as NA 4-6) to objectively determine whether the eved and sustained demonstrable	sustain the desired NA
Chapter 5 - Quality Management and Improveme		Subchapter IIa - Quality Improvement Topics	Rating scale for QI studies: SC = Substantially compliant (meets standards) PC = Partially compliant (needs improvement) NC = Non-compliant N/A = Not applicable * = Study ongoing; cannot rate item yet	Quality Improvement Topic #1 (Name of study):	A statement of the purpose of the QI activity that includes a description of the known or suspected problem, and explains why it is significant to the organization.	Identification of the performance goal against which the organization will compare its current performance in the area of study.	Description of the data that will be collected in order to determine the organization's current performance.	Evidence of data collection.	Data analysis that describes findings about the frequency, severity and source(s) of the problem(s).	A comparison of the organization's current performance in the area of study against the previously identified performance goal.	Implementation of corrective action(s) to resolve identified problem(s)	Re-measurement (a second round of data collection and analysis as described in Standard 5.II. B-4-6) to objectively determine whether the corrective actions have achieved and sustained demonstrable improvement.	If the initial corrective action(s) did not achieve and/or sustain the desired
- Quality M	CMS												
Chapter 5	Standard			11a	01-1	QI1-2	QI1-3	Q11-4	Q11-5	Q11-6	QI1-7	8-11-8	QI1-9

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nce nce sww ig res nce AS ds	Suspected problem with new CMS documentation on nursing part of patient record.	100% compliance goal set	Three items for data collection identified.	Data collection done in charts reviewed.	Data analysis done.	Only physician signature in discharge order from Recovery Room at 100% compliance.	New charting practice for staff done.	Re-measurement done and results did not met 100% goal.	Center almost met its goal of 100% documentation compliance.	Communication on study done for everyone in the organization.	ion es- kion
Tracking Compliance with New Charting Procedures in Accordance with CMS Standards	SC	SC	SC	၁၄	SS	SC	sc	SC	S	SC	e Injection Practices- An Infection
Quality Improvement Topic #3 (Name of study):	A statement of the purpose of the QI activity that includes a description of the known or suspected problem, and explains why it is significant to the organization.	Identification of the performance goal against which the organization will compare its current performance in the area of study.	Description of the data that will be collected in order to determine the organization's current performance.	Evidence of data collection.	Data analysis that describes findings about the frequency, severity and source(s) of the problem(s).	A comparison of the organization's current performance in the area of study against the previously identified performance goal.	Implementation of corrective action(s) to resolve identified problem(s).	Re-measurement (a second round of data collection and analysis as described in Standard 5.II.B-4-6) to objectively determine whether the corrective actions have achieved and sustained demonstrable improvement.	If the initial corrective action(s) did not achieve and/or sustain the desired improved performance, implementation of additional corrective action(s) and continued remeasurement until the problem is resolved or is no longer relevant.	Communication of the findings of the quality improvement activities to the governing body and throughout the organization, as appropriate, and incorporation of such findings into the organization's educational activities ("dosing the QI loop").	Quality Improvement Topic #4 (Name of study):
ଠାଓ	QI3-1	QI3-2	Q13-3	QI3-4	QI3-5	Q13-6	QI3-7	Q13-8	Q13-9	QI3-10	Q14

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		Control Self-Assess ment	
014-1	A statement of the purpose of the QI activity that includes a description of the known or suspected problem, and explains why it is significant to the organization.	၁၄	Purpose of study stated.
QI4-2	Identification of the performance goal against which the organization will compare its current performance in the area of study.	SS	A performance goal of 100% compliance set.
QI4-3	Description of the data that will be collected in order to determine the organization's current performance.	SS	Data collected by staff observation and interview of compliance.
Q14-4	Evidence of data collection,	SC	Data collection done on 10 employees for 2 days.
QI4-5	Data analysis that describes findings about the frequency, severity and source(s) of the problem(s).	SC	Data analysis done.
Q14-6	A comparison of the organization's current performance in the area of study against the previously identified performance goal.	sc	Both employees met compliance standards.
Q14-7	Implementation of corrective action(s) to resolve identified problem(s).	NA	
014-8	Re-measurement (a second round of data collection and analysis as described in Standard 5.II.B.4-6) to objectively determine whether the corrective actions have achieved and sustained demonstrable improvement.	A	
Q14-9	If the initial corrective action(s) did not achieve and/or sustain the desired improved performance, implementation of additional corrective action(s) and continued remeasurement until the problem is resolved or is no longer relevant.	ĄN	
014-10	Communication of the findings of the quality improvement activities to the governing body and throughout the organization, as appropriate, and incorporation of such findings into the organization's educational activities ("closing the QI loop").	SC	Results reported to QAPI Committee, Study did not document reporting to the governing board.
QI5	Quality Improvement Topic #5 (Name of study):		
Q15-1	A statement of the purpose of the QI activity that includes a description of the known or suspected problem, and explains why it is significant to the organization.		
Q15-2	Identification of the performance goal against which the organization will compare its current performance in the area of study.		

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Q15-3	Description of the data that will be collected in order to determine the organization's current performance.		
QI5-4	Evidence of data collection.		
QI5-5	Data analysis that describes findings about the frequency, severity and source(s) of the problem(s).		
Q15-6	A comparison of the organization's current performance in the area of study against the previously identified performance goal.		
QI5-7	Implementation of corrective action(s) to resolve identified problem(s).		
Q15-8	Re-measurement (a second round of data collection and analysis as described in Standard 5.II.B-4-6) to objectively determine whether the corrective actions have achieved and sustained demonstrable improvement.		
QI5-9	If the initial corrective action(s) did not achieve and/or sustain the desired improved performance, implementation of additional corrective action(s) and continued remeasurement until the problem is resolved or is no longer relevant.		
QI5-10	Communication of the findings of the quality improvement activities to the governing body and throughout the organization, as appropriate, and incorporation of such findings into the organization's educational activities ("closing the QI loop").		
ASK-1	In what year did the organization begin to conduct quality improvement studies?	2006	
ASK-2	How many studies has the organization conducted?	9	
ASK-3	This year?	2	
ASK-4	Last year?	2	
ASK-5	Previous year?	2	
ASK-6	How many benchmarking activities have been conducted?	39	
ASK-7	This year?	41	
ASK-8	Last year?	13	
ASK-9	Previous year?	12	

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ASK-10	How many studies were reviewed during the survey?	4	
	Consultative Comments		Consultative Comments
			Suggest doing a QI study for each satellite location only.

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Chapter	5 - Quality M	Chapter 5 - Quality Management and Improvement - Risk Management III	t III	
Standard	CMS		Compliance Rating	Comments
		Subchapter III - Risk Management: An accreditable organization develops and maintains a program of risk management, appropriate to the organization, designed to protect the life and welfare of an organization's patients and employees. Such an organization has the following characteristics:	SC	
4		The governing body of the organization is responsible for overseeing the program of risk management that includes the elements listed in Standard 5.III.C, and as appropriate to the organization, requirements described in Subchapter I of Chapter 2, and Chapter 3.	SC	The RN Administrator at the center and an individual from AmSurg corporate office are in charge of the risk management program
Ф		A designated person or committee is responsible for the risk management program.	SC	The Center Administrator serves as the GI Center on-site Risk Manager.
O		Elements of a risk management program address safety of patients and other important issues, which include:	SC	All of the below elements are reflected in the risk management program activities. All incident reports are reviewed, addressed, and reported to the QAPI committee with final resolution with each incident. The center utilized the risk management form from AmSurg Corporate Risk Management.
2		Consistent application of the risk management program throughout the organization, including all departments and all service locations	SC	All surveyed sites were consistent in their documentation and staff knowledge of the program.
C-2		Methods by which a patient may be dismissed from care or refused care	sc	
S-23		Reporting, reviewing and appropriate analysis of all incidents reported by employees, patients, health care professionals and others.	sc	All incidents are documented in a center log at each site with well written documentation being noted. All patient complaints are investigated by the Center Director and the Medical Director. This is incorporated in a written report to the QAPI committee.
3		Review of all deaths, trauma, or other adverse incidents as defined in Standard 2.1.B-21, including reactions to drugs and materials	PC	Some hospital transfers were not properly identified in 2011 as an incident per AmSurg Risk Management definition guidelines.
C-5		Review and analysis of all actual and potential infection control occurrences and breaches, surgical site infections, and other health-care acquired infections in accordance with the plan of action as detailed in 7.1.B-5.	SC	
မှ ပ		Periodic review of all litigation involving the organization and its staff and health care professionals	SC	This is handled by the Operating Board.

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C-7	Review of patient complaints	SC	This organization benchmarks all patient satisfaction results.
C-8	Communications with the professional liability insurance carrier	sc	
6-O	Managing a situation in which a health care professional becomes incapacitated during a medical or surgical procedure	SC	There is a written policy which addresses an incapacitated health care professional.
C-10	Impaired health care professionals	SC	The center has a written policy which addresses an impaired health care professionals.
C-11	Establishment and documentation of coverage after normal working hours	SC	This information is given to all patients and as well as communication on an after hours phone message. Patients have access to on call Gl physicians through the office answering service.
C-12	Methods for prevention of unauthorized prescribing	sc	All prescription pads were secure.
C-13	Processes to identify and/or designate the surgical site and involve the patient in those processes.	sc	Proper time-out involving the patient was observed by the surveyor prior to the start of endoscopy procedure.
C-14	Active surveillance of processes and techniques for detection and prevention of disease, infection and potential communicable infective sources with direct intervention when appropriate	SC	Ongoing infection control inspections are conducted by the infection control nurse with the support of other clinical staff.
۵	Only persons authorized by the governing body to perform or assist in the procedure are allowed in patient care areas except as identified in the organization's policy regarding observers in patient care areas.	SC	There is a written observer policy present for those who are allowed into the clinical areas,
ш	The organization must have a written policy that addresses all other persons allowed in patient care areas that are not authorized staff (students, interested physicians, health care industry representatives, surveyors, etc.) including evidence of patient consent.	sc	
LL.	The risk management program requires a periodic review of clinical records and clinical record policies.	SC	The physician and clinical staff review of clinical records at this organization is incorporated in the overall risk management program.
O	Education in risk management activities, including infection control and safety policies and processes, is provided to all staff within thirty (30) days of commencement of employment, annually thereafter, and when there is an identified need.	SC	Staff education is completed within the first 30 days of employment which is documented in each employee file.
	Consultative Comments		Consultative Comments Suggest the Operating Board review with AmSurg Corporate Risk Manager their incident reporting policy/process for transfers from the center to a receiving hospital.

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Chapter (	6 - Clinical R	Chapter 6 - Clinical Records and Health Information		
Standard	CMS		Compliance Rating	Comments
		An accreditable organization maintains electronic and/or paper clinical records and a health information system from which information can be retrieved promptly. Clinical records are complete, comprehensive, legible, documented accurately in a timely manner and readily accessible to health care professionals.		
		Overall Chapter Compliance Level	SC	
		Number of patient files reviewed during the survey:	15	
		Description of how records were selected:		A random selection of 1 chart from each of the 9 endoscopists at the center, a review of 5 unplanned hospital transfers, and a review of the 1 LASER case.
<		The organization develops and maintains a system for the proper standardized collection, processing, maintenance, storage, retrieval and distribution of patient records.	SC	All medical records are maintained electronically.
œ		An individual clinical record is established for each person receiving care. Each record includes, but is not limited to:	SC	
8-1		Name	SC	Several identifiers are present in the medical record including the patient's name.
B-2		Identification number (if appropriate)	SC	Each patient is assigned a medical record number,
B-3		Date of birth	SC	Date of birth is present on all charts.
B-4		Gender	sc	Gender is present on the chart.
B-5		Responsible party, if applicable.	SC	
U		All clinical information relevant to a patient is readily available to authorized personnel any time the organization is open to patients.	SC	All information is readily available and retrievable on the electronic medical record.
D		Clinical record entries are legible and easily accessible within the record by the organization's personnel.	SC	All entries are standardized and the electronic medical record is very easy to navigate.
ш		Except when otherwise required by law, any record that contains clinical, social, financial or other data on a patient is treated as strictly confidential	SC	All information is stored on a password protected intranet.

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	and is protected from loss, tampering, alteration, destruction, and unauthorized or inadvertent disclosure.		
LL.	A designated person is in charge of clinical records. This person's responsibilities include, but are not limited to:	SC	All records are maintained electronically. There is a dedicated IT person on staff.
F-1	The confidentiality, security and physical safety of records	NA	
F-2	The timely retrieval of individual records upon request	sc	All records and reports are immediately retrievable.
F3	The unique identification of each patient's record	SC	Each patient is identified by name, birth date and medical record number.
F4	The supervision of the collection, processing, maintenance, storage, and appropriate access to and usage of records	SC	All records are maintained and stored electronically.
F-5	The maintenance of a predetermined, organized and secured record format.	SC	The medical record is organized in a very intuitive fashion. It is quite easy to navigate through a patients chart.
9	Policies concerning clinical records address, but are not limited to:	sc	
G-1	The retention of active records	sc	
6-2	The retirement of inactive records	sc	
6-3	The timely entry of data in records	SC	All charts reviewed were signed within 24 hours.
G-4	The release of information contained in records	SC	
I	Except when otherwise required by law, the content and format of clinical records, including the sequence of information, are uniform. Records are organized in a consistent manner that facilitates continuity of care.	sc	There is absolute consistency in the format of all medical records.
-	Reports, histories and physicals, progress notes and other patient information (such as laboratory reports, x-ray readings, operative reports, and consultations) are reviewed and incorporated into the record in a timely manner.	SC	All reports, labs, notes, consults, etc are placed in the medical record immediately.
٦	If a patient has had multiple visits/admissions, or the clinical record is complex and lengthy, a summary of past and current diagnoses or problems, including past procedures, is documented in the patient's record to facilitate the continuity of care.	SC	Summaries are present, and history and physicals are updated as needed.
×	The presence or absence of allergies and untoward reactions to drugs and materials is recorded in a prominent and consistent location in all clinical records. This is verified at each patient encounter and updated whenever new allergies or sensitivities are identified.	SC	The allergy notation is prominent in many parts of the electronic medical record.

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-	Entries in a patient's clinical record for each visit include, but are not limited to:	SC	
L-1	Date (and department, if departmentalized).	SC	Date was present on all charts.
L-2	Chief complaint or purpose of visit	SC	Chief complaint was present on all charts.
L-3	Clinical findings	သွ	Findings were present as were photographs of the exams when applicable.
L4	Discharge diagnosis or impression	သွ	Assessment and plan was noted on all charts as was impressions and diagnosis.
L-5	Studies ordered, such as laboratory or x-ray studies	SC	All labs are accessible on the record.
P-7	Care rendered and therapies administered	SC	
L-7	Any changes in prescription and non-prescription medication(s) with name and dosage, when available	SC	Current medications that the patient is taking are rechecked with each patient visit.
F-8	Disposition, recommendations and instructions given to the patient	SC	Patient is given both oral and written discharge instruction. The printed discharge instructions are present on the chart.
6-7	Authentication and verification of contents by health care professionals	SC	All charts and reports were signed in a timely fashion.
L-10	Documentation regarding missed and canceled appointments	SC	There is a section in the electronic medical record for missed and canceled appointments.
L-11	Signature of physician or other author of the clinical record entry	SC	All records were signed in a timely fashion.
M	Significant medical advice given to a patient by telephone or online is entered in the patient's clinical record and appropriately signed or initialed, including medical advice provided by after-hours triage services.	SC	
Z	Any notation in a patient's clinical record indicating diagnostic or therapeutic intervention as part of clinical research is clearly contrasted with entries regarding the provision of non-research related care.	NA	
0	The organization is responsible for ensuring a patient's continuity of care. If a patient's primary or specialty care provider(s) or health care organization is elsewhere, the organization ensures that timely summaries or pertinent records necessary for continuity of patient care are:	SC	Letters to outside physicians are maintained in the electronic medical record and are dated. All those observed were sent in a timely fashion.
0-1	Obtained from the other (external) provider(s) or organization and incorporated into the patient's clinical record	SC	All outside information is scanned and included in the medical record.
0-2	Provided to the other (external) health care professional(s) or consultant	SC	All outgoing letters are included in the medical record.

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and, as appropriate, to the organization where future care will be provided			- 1
Discussions with the patient concerning the necessity, appropriateness and risks of proposed care, surgery or procedure, as well as discussions of treatment alternatives and advance directives, as applicable, are incorporated into the patient's medical record.	SC	A written consent is present in the chart and is signed by the patient and physician.	
Consultative Comments		Consultative Comments	

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Chapter	7 - Infection	Chapter 7 - Infection Prevention and Control		
Standard	CMS		Compliance Rating	Comments
		Preamble: An accreditable organization provides health care services while adhering to safe practices for patients, staff and all others. The organization maintains ongoing programs designed to (1) prevent and control infections and communicable diseases, and (2) to provide a safe and sanitary environment of care.		
		Overall Chapter Compliance Level	sc	The recent retirement of the previous infection control officer led to the transition of this excellent program to an energetic staff member who is learning the details of this complex program.
		Subchapter I - Infection Prevention and Control: An accreditable organization maintains an active and ongoing infection control and prevention program as evidenced by the following characteristics:	SC	
<		The organization must establish a program for identifying and preventing infections, maintaining a sanitary environment, and reporting the results to appropriate authorities.	SC	The Infection Control Nurse is responsible for all three site locations. Any issue is identified and reported to the RN Administrator and the Medical Director. A report is prevented to each QAPI Committee meeting.
Ф		The infection prevention and control program includes documentation that the organization has considered, selected, and implemented nationally-recognized infection control guidelines. The program is:	SC	
B-1		Approved by the governing body	SC	
B-2		An integral part of the organization's quality improvement program	SC	A cross functional team of the Endoscopy Center's leadership provides oversight of the infection control program. Discussion and information presented at the meeting is considered for inclusion in the quality improvement efforts.
B-3		Under the direction of a designated and qualified health care professional who has training and current competence in infection control	SC	The current person is a trained and competent infection control officer. She has taken a number of courses and has a number of contact hours. There is a plan for this person to become certified by APIC.
4		Appropriate to the organization and meets all applicable state and federal requirements	SC	
B-5		Responsible for providing a plan of action for preventing, identifying, and managing infections and communicable diseases and for immediately implementing corrective and preventive measures that result in improvement	သွ	

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SC	SC The program is in line with guidelines established by CDC. Continuous monitoring and staff incident reports provide information to the staff for changes to the program.	SC	OS SE	SC	SC An excellent disinfection program for procedure equipment exists and is effectively managed throughout the organization sites to include required reprocessing of equipment not used within the proscribed time and daily testing of solution used in the disinfection process.	Sharps containers are available and appropriately managed throughout the organization. Handling and disposal of filled sharps containers is the responsibility of staff members who manage assigned patient treatment areas.	SS	lant SC ses	SC Sharps containers are available and in all patient care areas throughout the organization.	SC	SC	s to SC n of	SC A clear and accurate medical equipment log is maintained by the organization's staff to ensure surveillance on medical equipment is maintained. Cleaning and high level disinfection policies and procedures
Clear to include direct intervention to prevent infection, as needed	The infection control and prevention program reduces the risk of health care-acquired infection as evidenced by education and active surveillance, consistent with:	WHO, CDC or other nationally-recognized guidelines for hand hygiene	CDC or other nationally-recognized guidelines for safe injection practices	Precautions to minimize communicable disease exposure to patients, health care staff and others.	The organization provides a functional and sanitary environment for the provision of services. The organization adheres to professionally accepted standards of practice, manufacturer's recommendations, and state and federal guidelines, including but not limited to the cleaning, disinfection and sterilization of instruments, equipment, supplies, and implants.	A sharps injury prevention program must be present in the organization. Such a program will include:	Documentation of employee orientation and annual staff education	Disposal of intact needles and syringes into appropriate puncture-resistant sharps containers, in accordance with current state and federal guidelines	Placement of sharps containers in appropriate care areas, secured from tampering	Replacement of sharps containers when the fill line is reached	Handling and disposal of filled sharps containers in accordance with applicable regulations	A safe environment for treating patients, including adequate safeguards to protect the patient from cross-infection, is assured through the provision of adequate space, equipment, supplies and personnel.	Procedures must be available to minimize the sources and transmission of infections, including adequate surveillance techniques.
B-6	U	2	C-2	ű	۵	ш	7	E-2	F-3	E 4	E-5	LL.	O

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SC The Endoscopy Center staff is effectively managing the high-level disinfection of medical equipment. The standards and policies in place ensure equipment are within current dates.	SC The effectiveness of the equipment and supplies effectiveness used in the disinfection process is verified through timely preventive maintenance and testing. See comment in item 7.1.D,	SC A comprehensive corporate policy was present that addressed managing patients with communicable disease.	SC Staff was knowledgeable and demonstrated responsibilities for cleaning patient treatment areas.	SC	SC	SC	Consultative Comments
A process is in place for the monitoring and documentation of the cleaning, high-level disinfection and sterilization of medical equipment, accessories, instruments and implants. Sterile packs of equipment and instruments are within current dates.	A policy addresses the identification and processing of medical equipment and instruments that fails to meet sterilization parameters.	Policies are in place for the isolation or immediate transfer of patients with a communicable disease.	The organization's written policies address cleaning of patient treatment and care areas which, at a minimum address:	Cleaning before use	Cleaning between patients	Terminal cleaning at the end of day	Consultative Comments
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I		٦	¥	K-1	K-2	K-3	

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Standard       CMS         Subchapter II - Safety: An acc practices for patients, staff and characteristics:         A       Elements of a safety program a care and the safety of patients, exceed local, state or federal as safety program include, but are exceed local, state or federal as safety program include, but are process includents to appropriate state at the arm misses and other safety or do so.         A-3       An awareness of, and a process includents to appropriate state at to do so.         A-4       Processes to reduce and avoid medications, medical equipment prevention of falls or physical in others         C       Medical staff members, employ program, and receive education be limited to:         C-1       Infection control and prevention			
		Compliance Rating	Comments
	Subchapter II - Safety: An accreditable organization adheres to safe practices for patients, staff and others as evidenced by the following characteristics:	SC	
	Elements of a safety program address the organization's environment of care and the safety of patients, staff, and others, and must meet or exceed local, state or federal safety requirements. The elements of the safety program include, but are not limited to:	sc	The center safety program covers the below elements.
	Processes for the management of identified hazards, potential threats, near misses and other safety concerns	SC	
	An awareness of, and a process for, the reporting of known adverse incidents to appropriate state and federal agencies when required by law to do so	sc	
	Processes to reduce and avoid medication errors	PC	While look alike, sound alike medications were appropriately managed at one of the satellites, this information was not consistently managed at each site.
	Policies regarding food and drink, if made available	sc	
	Policies addressing manufacturer or regulatory agency recalls related to medications, medical equipment and devices, and food products	SC	The Endoscopy Center has an effective program for managing any equipment, medication and supply recalls that effect the organization.
	Prevention of falls or physical injuries involving patients, staff, and all others	SC	
	There is a person or committee designated by the governing body who is responsible for the organization's safety program.	sc	A safety officer was appointed and approved by the governing board.
	Medical staff members, employees, volunteers and others abide by the program, and receive education and training to include but not necessarily be limited to:	သွ	Infection control and safety program requirements and information are presented to each staff member during initial orientation and annual training sessions.
	infection control and prevention program	SC	
C-2 Safety program	ш	SC	
D Unique patient id	Unique patient identifiers are consistently used throughout care.	SC	

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ш	The	The organization has written policies regarding procedures and treatments that are offered to patients, which include criteria for patient selection, the need for anesthesia support, and post-procedural care.	sc	The is a written policy which outlines the criteria for patients who could have a endoscopy procedure done in this setting.
LL.	The property of the property o	The organization has a comprehensive written emergency and disaster preparedness plan to address internal and external emergencies, including participating in community health emergency or disaster preparedness, when applicable. The written plan must include a provision for the safe evacuation of individuals during an emergency, especially individuals who are at greater risk.	SC	Emergency and disaster preparedness plans address the safe evacuation or protection of patients and staff members in the case of natural disasters or emergencies.
O	T. edu.	The organization adopts the appropriate policies and procedures to educate providers and personnel in fire prevention and fire hazard reduction.	SC	
I	Fire	Fire safety, fire prevention and fire drills are included in the surveillance activities of personnel responsible for safety and risk management.	sc	See comment in 8.E,
_	En	Environmental hazards associated with safety are identified and safe practices are established.	SC	
7	Me	Measures are implemented to prevent skin and tissue injury from chemicals, cleaning solutions and other hazardous exposure.	SC	Appropriate PPE is available and used at each facility within the organization.
¥	Evi and and	Evidence of compliance with local, state and federal guidelines is present and adhered to regarding preparing, serving, disposal and storing of food and drink for patient use.	SC	Patients are only provided drinks and these items are appropriately managed and stored.
7	Pai pro	Patients are educated about prescribed medical devices and associated protocols and guidelines. Patient competence with each device is verified before independent use.	N A	
Σ	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	Reprocessing of single-use devices must comply with FDA guidelines, and the devices must have been cleared under the FDA 510(k) process. Policies must clearly dictate the cleaning and handling of these devices in-house before sending them out for reprocessing. A written log must be maintained on all reprocessed devices.	NA	
z	त्ते de de	The organization has a policy and process that addresses the recall of items including drugs and vaccines, blood and blood products, medical devices, equipment and supplies, and food products. At a minimum, the policy addresses:	SC	Oversight of recalled equipment is provided through the medical equipment management program and recalled supplies and medication oversight is provided by the safety officer. Determination if the recall impacts the organization is accomplished through records reviews and any required notification occurs within a dedicated program.
N-1	So	Sources of recall information (FDA, CDC, manufacturers, and other local, state or other federal sources)	SC	
N-2	Me	Methods of notification of staff that need to know	SC	

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			No patient notification was required for the recalled equipment reviewed.	Medication and supplies are effectively managed to ensure expired items are removed and returned or destroyed.	Education is provided by the manufacturer's representative and prior to equipment use the equipment engineer verifies performance parameters are in line with specifications. This education is under the supervision of the Clinical Managers.		Consultative Comments	Consider locating the MSDS data sheets closer to staff who may need to access the information. Examples are the nurses station and storage rooms where chemicals are stored.
SC	SC	SC	SC	SC	SC	SS		
Methods to determine if a recalled product is present at the organization or has been given or administered to patients	Documentation of response to recalled products	Disposition or return of recalled items	Patient notification, as appropriate	Products, including medications, reagents and solutions, that carry an expiration date are monitored. The organization has a policy for disposal or return of expired medications and supplies that is in accordance with local, state and federal guidelines.	Prior to use, appropriate education is provided to intended operators of newly-acquired devices or products to be used in the care of patients.	The organization shall designate a person to be responsible for ensuring that appropriate clinical education occurs prior to allowing the use of the device in the care of a patient. Vendor representatives are not used as the sole source for clinical education.	Consultative Comments	
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N-3	4 4	N-5	N-6	0	Ф	P-1		

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Chapter	8 - Facilities	Chapter 8 - Facilities and Environment		
Standard	CMS		Compliance Rating	Comments
		An accreditable organization provides a functionally safe and sanitary environment for its patients, personnel, and visitors. Such an organization has the following characteristics.		
		Overall Chapter Compliance Level	SC	The Endoscopy Center LLC maintains three separate facilities with over 15,000 square feet and perform over 21,000 endoscopy procedures each year. The facilities are in excellent condition and are adequately equipped to provide the care required to their patients. Recent construction was done at one site to address CMS standards.
⋖		The organization provides evidence of compliance with the following:	sc	
A-1		Applicable state and local building codes and regulations	SC	The state of Tennessee has reviewed and licensed the organization to operate as a health care facility.
A-2		Applicable state and local fire prevention regulations, such as the NFPA 101® Life Safety Code,® 2000 Edition, published by the National Fire Protection Association, Inc.	SC	The Endoscopy Center has undergone several CMS inspections and has aggressively corrected noted deficiencies. One exception was the Feb 12 CMS report directed weekly inspection of security of all fire doors. The organization had yet to implement weekly checks to ensure the fire doors were working correctly but did conduct monthly checks.
A-3		Applicable federal regulations	sc	
A-4		Periodic inspection by the local or state fire control agency, if this service is available in the community	NA	While the Knoxville Fire Department inspects all new commercial construction and remodels, there are no periodic inspections conducted.
В		The organization ensures that its facilities:	SC	
B-1		Contain fire-fighting equipment to control a limited fire, including appropriately maintained and placed fire extinguishers of the proper type for each potential type of fire	SS	Fire extinguishers were available at all three operating locations and staffs were trained on the operation of extinguishers during initial orientation and again during annual training programs.
B-2		Have prominently displayed illuminated signs with emergency power capability at all exits, including exits from each floor or hall	SC	
B-3		Have emergency lighting, as appropriate to the facility, to provide adequate illumination for evacuation of patients and staff, in case of an emergency	SC	Emergency lighting is connected to the alternate power source in all facilities. The lighting is tested each month to ensure effective operation.
B 4		Have stairwells protected by fire doors, when applicable	SC	See comment in A-2.

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B-5	Provide reception areas, toilets, and telephones in accordance with patient and visitor volume	SC	
B-6	Provide examination rooms, dressing rooms, and reception areas that are constructed and maintained in a manner that ensures patient privacy during interviews, examinations, treatment and consultation	သွ	While patient treatment/interaction areas have privacy curtains, during the facility walk through at the North satellite, not all curtains were closed during staff patient interactions.
B-7	Provide adequately marked patient and visitor parking, when appropriate	SC	
B-8	Are operated in a safe and secure manner	SC	
U	The organization has the necessary personnel, equipment and procedures to deliver safe care, and to handle medical and other emergencies that may arise.	SC	Emergency equipment was available at all operating locations. Staff was educated on the location of the equipment and organization of the supplies.
Q	The organization provides documented periodic instruction of all personnel in the proper use of safety, emergency, and fire-extinguishing equipment.	SC	See comment in B-1.
ш	The organization requires at least one (1) drill each calendar quarter of the internal emergency and disaster preparedness plan. One (1) of the annual drills must be a documented cardiopulmonary resuscitation (CPR) technique drill, as appropriate to the organization. The organization must complete a written evaluation of each drill, and promptly implement any needed corrections or modifications to the plan.	၁၄	Quarterly drills were conducted at each facility and evaluations were accomplished to record changes or additional training required by personnel. Follow-up drills were conducted to ensure any deficiencies identified were corrected.
L	Personnel trained in cardiopulmonary resuscitation and the uses of cardiac and all other emergency equipment are present in the facility to provide patient care during hours of operation.	SC	All RNs and CRNAs are ACLS certified.
Ð	Smoking is prohibited within the facility.	SC	
I	Hazards that might lead to slipping, falling, electrical shock, burns, poisoning or other trauma are eliminated.	SC	
-	Provisions are made to reasonably accommodate disabled individuals.	SC	
7	Adequate lighting and ventilation are provided in all areas.	SC	
*	Facilities are clean and properly maintained.	sc	All facilities are clean and well maintained to support the physical environment of care.
_	Food services and refreshments provided to patients meet their clinical needs and are prepared, stored, served and disposed of in compliance with local state and federal health department requirements.	SC	See comment in 7.II.K.
Σ	A system exists for the proper identification, management, handling,	SC	

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jacent	age area to	hazard		11
insider moving the Hazardous Material storage area to an ad	rage room without the sump pit and pump. Moving the stor.	adjacent room will enhance efforts to contain any spill or bio	iste to the immediate area.	
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				Ш

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Chapter	9a - Anesthe	Chapter 9a - Anesthesia Information		
Standard	CMS		Compliance Rating	Comments
		Chapter 9a - Anesthesia Info		
		If the organization provides any anesthesia services, please select the "X" to mark the appropriate boxes below. If no anesthesia services are provided, leave this page blank.		
		Indicate all levels of anesthesia provided:		
		Local or topical anesthesia - The application of local anesthetic agents, in appropriate doses adjusted for weight.		
		Minimal sedation (anxiolysis) - A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected. Inhaled nitrous oxide in low concentrations that would not reasonably be expected to result in loss of the patient's life-preserving protective reflexes would be considered minimal sedation.	×	
		Moderate sedation/analgesia (conscious sedation) - A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light factile stimulation. No interventions are required to maintain a patent ainway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.	×	
		Regional anesthesia - The application of anesthetic medication around the nerve or nerves in a major region of the body, which supply the area which is targeted for the abolition of painful neural impulses. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.		
		Deep sedation/analgesia - A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patient airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.	×	
		General anesthesia - A drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive		

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								The practice functions with a CRNA providing moderate to deep sedation under the supervision of the endoscopist, and the endoscopists provide minimal to moderate sedation with an RN injecting the medications.
			×	×			×	
pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function.  Cardiovascular function may be impaired.	Indicate all health care providers privileged to provide anesthesia:	Anesthesiologist	Surgeon	CRNA	Registered Nurse	Anesthesiologist Assistant	Others (Please list below):	Specify
								-

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Chapter	Chapter 9 - Anesthesia Services	ia Services		
Standard	CMS		Compliance Rating	Comments
		Chapter 9 - Anesthesia Services		
		Anesthesia services in an accreditable organization are provided in a safe and sanitary environment by qualified health care professionals who have been granted privileges to provide those services by the governing body. Such an organization has the following characteristics.		
		Overall Chapter Compliance Level	sc	
		Was the delivery of sedation or anesthesia observed?	Yes	
		If so, what level?	Moderate to deep sedation.	
		The sedation/anesthesia was provided by:	CRNA	
		The sedation/anesthesia was supervised by:	The endoscopist.	
		Standards A-I below will be applied at organizations involved in the administration of sedation and anesthesia, including those where only local or topical anesthesia, or only minimal sedation is administered.		
ď		Anesthesia services provided in the facilities owned or operated by the organization are limited to those techniques that are approved by the governing body upon the recommendation of qualified professional personnel. Anesthesia services are performed only by health care professionals who have been credentiated and granted clinical privileges by the organization in accordance with Subchapter II of Chapter 2.	S	Moderate to deep sedation with propofol is administered
œ		Adequate supervision of anesthesia services provided by the organization is the responsibility of one or more qualified physicians or dentists who are approved and have privileges for supervision granted by the governing body.	SC	The anesthetic is delivered by the CRNA and is supervised by the endoscopist. All are credentialed by the governing board.
U		Policies and procedures are developed for anesthesia services, which include, but are not limited to:	သွ	

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C-1	Education, training and supervision of personnel	sc	Policy in place that delineates the responsibility of the CRNA and the endoscopist.
C-2	Responsibilities of non-physician anesthetists	os .	CRNA responsibilities are outlined in the policy and procedure manual.
C-3	Responsibilities of supervising physicians and dentists.	sc	Policy and procedure manual delineates the responsibility of supervision of the CRNA to the endoscopist.
Q	A physician, dentist, or a qualified health care professional supervised by a physician or dentist, approved by the governing body, examines the patient immediately prior to the anesthetic to evaluate the risks of anesthesia relative to the procedure to be performed and develops and documents a plan of anesthesia.	SC	A CRNA (supervised by the endoscopist) interviews the patient immediately before entering the procedure suite. The risks and benefits are signed off on by the patient in the anesthesia consent.
ш	The informed consent of the patient or, if applicable, of the patient's representative, is obtained before the procedure is performed. One consent form may be used to satisfy the requirements of this standard and Standard 10.1.T.	SC	The patient signs a separate consent for the procedure and for the anesthetic,
ш	Anesthesia is administered by anesthesiologists, other qualified physicians, dentists, certified registered nurse anesthetists, other qualified health care professionals approved by the governing body pursuant to Chapter 2.II. Other qualified health care professionals must be directly supervised by a physician or dentist who has been privileged for such supervision.	sc	Anesthetics are all performed by qualified CRNA's supervised by the endoscopists. All are properly educated and qualified,
9	The facility must be established, constructed, equipped and operated in accordance with applicable local, state and federal laws and regulations. At a minimum, all settings in which sedation or anesthesia is administered should have the following equipment for resuscitation purposes:	SC	
6-1	Reliable and adequate source of oxygen delivery	SC	Oxygen condensers are used with H-cylinder backup. There is no piped oxygen in the main center.
G-2	A device such as a self-inflating hand resuscitator bag capable of administering at least 90% oxygen	SC	There is a self-inflating hand resuscitator device in all procedure areas and one on the crash cart.
G-3	Appropriate emergency drugs, supplies and equipment	SC	Crash cart was adequately stocked and equipped. All equipment was maintained according to manufacturers recommendation and was checked daily. All drugs were within expiration date.
G-4	Appropriate monitoring equipment for the intended anesthesia care	SC	All procedure rooms and PACU bays were equipped with ECG, NIBP, O2 saturation.
G-5	Reliable suction source and appropriate equipment to ensure a clear airway.	SC	A dedicated anesthesia portable suction device was present in all procedure areas.
I	All clinical personnel with direct patient contact maintain at a minimum	SC	All have BLS, and most staff has ACLS certification.

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skills in basic cardiac life support (BLS).  Clinical records include entries related to anesthesia administration.	SC	The anesthesia record is part of the medical record and is referenced in
Standards J-W below will be applied at organizations that administer moderate sedation/analgesia, deep sedation/analgesia, regional anesthesia.		
A patient's oxygenation, ventilation and circulation must be continually evaluated and documented. Intra-operative physiologic monitoring must include: continuous use of a pulse oximeter, blood pressure determination at frequent intervals, and electrocardiogram (EKG) monitoring for patients with significant cardiovascular disease during moderate sedation, and for all patients during deep sedation/analgesia or general anesthesia. Monitoring for the presence of exhaled CO2 is recommended during the administration of deep sedation.	S	Continual ECG, NIBP monitoring and oxygen saturation monitoring is performed and recorded at frequent intervals. ETCO2 monitoring is not yet done.
The organization maintains a written policy with regard to assessment and management of acute pain.	SC	
The patient is observed and monitored in a post-anesthesia care unit or in an area which provides equivalent care by methods appropriate to the patient's medical condition and sedation or anesthesia.	SC	There is a large PACU for monitoring the patient after the procedure. The patient is monitored by an RN after a full sign out by the CRNA. Physiologic monitoring includes ECG, NIBP and O2 saturation.
A physician or dentist is present until the medical discharge of the patient following clinical recovery from surgery/procedure and anesthesia.	SC	All cases finish by noon at the main center and physicians see patients in the offices after that. So there is always a physician present. The CRNA remains on site until the last patient is medically stable for discharge.
Before medical discharge from the facility, each patient must be evaluated by a physician, dentist, or delegated qualified heath care professional, supervised by a physician or dentist, approved by the governing body to assess recovery. If medical discharge criteria have previously been set by the treating physician or dentist, and approved by the governing body, a delegated qualified health care professional may determine if the patient meets such discharge criteria, and if so, may discharge when those criteria are met.	sc	Each patient is evaluated by the attending physician who did the procedure prior to discharge. That physician is responsible for writing the discharge order.
Health care professionals currently trained in advanced cardiac life support (ACLS), with documentation of successful completion and appropriate privileging to provide advanced resuscitative techniques, are present until all patients operated on that day have been physically discharged. When pediatric patients are served, health care professionals who are currently trained in PALS and age- and size-appropriate resuscitative equipment must be available at all times until pediatric patients operated on that day have been physically discharged. Initial ACLS and PALS training and subsequent retraining shall be obtained from the American Heart Association or another vendor that includes "hands-on" training and skills demonstration of airway management and	S	All nurses are ACLS certified and the center does not care for pediatric patients.

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	automated external defibrillator (AED) use.		
0	Patients who have received moderate sedation/analgesia, deep sedation/analgesia, regional anesthesia or general anesthesia are discharged in the company of a responsible adult.	SC	All patients must have an adult escort home.
۵	A safe environment for providing anesthesia services is assured through the provision of adequate space, equipment, supplies, medications, and appropriately trained personnel. Written policies must be in place for safe use of injectables and single-use syringes and needles. All equipment should be maintained, tested and inspected according to the manufacturer's specifications. A log is kept of regular preventive maintenance.	Sc	A log is present for all preventative maintenance. Multi dose vials are dated and initialed after opened. Single dose medications are not split up between patients. They are used for one patient only. There is adequate space in the procedure room to resuscitate a patient should need be.
G	Alternate power adequate for the type of surgery/service being performed is available in operative and recovery areas.	sc	All monitors have battery back-up
œ	Education and training in the recognition and treatment of malignant hyperthermia must occur before triggering agents are made available within the organization. Education and malignant hyperthermia drills are conducted at least annually thereafter when triggering agents are present within the organization. Organizations that have anesthetic and resuscitative agents available that are known to trigger malignant hyperthermia, must have written protocols to promote patient safety, such as the Malignant Hyperthermia Association of the United States (MHAUS) protocol. These treatment protocols must:	NA	The center does not stock any triggering agents for malignant hyperthermia.
R-1	Be posted and immediately available in each location where triggering agents might be used	NA	No triggering agents are used or stocked.
R-2	Include the use of dantrolene and other medications, and methods of cooling and monitoring of the patient.	ΑN	
ဟ	The organization has a written protocol in place for the safe and timely transfer of patients to a predetermined alternate care facility when extended or emergency services are needed to protect the health or well-being of the patient. Standard 4. K addresses medical emergencies that arise in connection with surgical procedures.	SC	There is a transfer agreement in place with a local hospital, Physician's Regional Medical Center (Previously Mercy Hospital). All physicians have admitting privileges at that hospital.
	Standard T will be applied to organizations that provide anesthesia services to children.		
L	Where anesthesia services are provided to infants and children, the required equipment, medication and resuscitative capabilities appropriate to pediatric patients are on site.	NA	The center does not care for pediatric patients.
ס	No patient shall receive moderate or deep sedation or general anesthesia unless a physician, dentist, or other qualified individual supervised by a	SC	All moderate to deep sedation is provided by a CRNA who has no other responsibilities besides administering the sedation and monitoring the

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>	2220 0 0 2.53	physician or dentist, in addition to the one performing the surgery, is present to monitor the patient. The operating physician or dentist may be the supervising physician or dentist. During moderate sedation, the additional individual may assist with minor, interruptible tasks.  Organizations that provide sedative, hypnotic or analgesic drugs that do not have an antagonist medication (for example, propofol) will identify who in the organization, as noted in Standard 9.F. is privileged to administer	SS	patients response.  There is a policy in place as to who can administer propofol, Only CRNAs can administer this drug.
		In settings where anesthesia may be provided by other than an anesthesiologist, oral and maxillofacial surgeon, certified registered nurse anesthetist, or an anesthesiologist assistant within his/her scope of practice, the organization has a written protocol that explains how the organization will respond in the event that a deeper-than-intended level of sedation occurs.	sc	All sedation with the exception of minimal sedation is performed by a CRNA. There is a policy in place for rescuing from a deeper level of sedation then expected.
	37 01	Standard X will be applied to organizations that administer deep sedation or general anesthesia.		
		In addition to the items noted in the previous anesthesia section, Standard J, administration of general anesthesia requires:	NA	This center does not provide general anesthesia. If a patient slips into general anesthesia from deep sedation and if intubation is required, the center has EZ caps available to check for CO2.
X-1		End-tidal CO2 monitoring	NA	
X-2		A readily available means of measuring body temperature	NA	
		Consultative Comments		Consultative Comments
				Consider utilizing ETCO2 monitoring for deep sedation. Consider stocking more commonly used laryngoscope sizes such as a MAC 3 and Miller 2 in the crash cart.

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equirements l	Compliance Comments Rating		organization are qualified health eges to perform trandards in this nvasive procedures, es, cardiac nn, as well as 3 characteristics.	SC	urvey? Yes	Colonoscop y	ne terms "surgery," geably. The use of method or ng, laser or tissues and organs,	zations that only nesthesia or under	shapter describes SC es surgical and	performed in a functional and sanitary SC The procedure was performed in an adequately sized, and well lit and ventilated room. The room has 3 walls and a curtain wall leading to pack that are approved by the procedure was performed in an adequately sized, and well lit and ventilated room to resuscitate a patient should the need arise.	roganization is a SC The procedure was perfumed entirely by the physician/endoscopist.  The procedure was perfumed entirely by the physician/endoscopist.
Chapter 10 - Surgical and Related Services - General Requirements I		Chapter 10 - Surgical and Related Services	Surgical and related services in an accreditable organization are performed in a safe and sanitary environment by qualified health care professionals who have been granted privileges to perform those procedures by the governing body. The standards in this chapter apply to organizations that provide any invasive procedures, such as pain management, endoscopy procedures, cardiac catheterization, lithotripsy, and in vitro fertilization, as well as surgery. Such an organization has the following characteristics.	Overall Chapter Compliance Level	Was a surgical procedure observed during the survey?	Name of procedure:	In this chapter and throughout this Handbook, the terms "surgery," "procedure" and "operation" are used interchangeably. The use of any of these terms is to reference any such skill, method or technique that involves cutting, abrading, suturing, laser or otherwise physically entering or changing body tissues and organs, including invasive pain management procedures.	Note: Some standards may not apply to organizations that only perform minor, superficial procedures without anesthesia or under local or topical anesthesia.	Subchapter I - General Requirements: This subchapter describes general requirements for an organization that provides surgical and related services.	Surgical procedures must be performed in a functional and sanitary environment and are limited to those procedures that are approved governing body upon the recommendation of qualified medical staff.	Adequate supervision of surgery conducted by the organization is a responsibility of the governing body. It is recommended that supervision
10 - Surgica	CMS										
Chapter	Standard									4	æ

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Surgical procedures must be performative providers who:  Are licensed to perform such procoganization is located Have been granted clinical privileg governing body, in accordance with appropriate and current health current prescription and non-presavailable, physical examination, a studies incorporated into the patie or according to local or state requising experience incorporated into the patie or according to local or state requising experience in procedure.  The use and timeliness of adminitiantibiotics is monitored to ensure Specific instructions for discontinute to and after a procedure are proving to adminitiantibiotics is monitored to ensure Specific instructions for discontinute to and after a procedure are provision of surgical services are provision of surgical services are and are available in sufficient nurcare provision of surgical services are and are available in sufficient nurcare provision of surgical services are and are available in sufficient nurcare provided.  Each operating room is designed and ensures the physical safety operating room is available for surgical services and and ensures the physical safety operating room is available for surgical services and and ensures the physical safety operating room is available for surgical services and and ensures the physical safety operating room is available for surgical services and and ensures the physical safety operating room is available for surgical services are surgery conducted can applicable state and ensures the physical safety operating room is available for surgical services are and are available for surgical services are and are available and an operating room, and in compliance with applicable state and ensures the physical safety of an early of surgical services and an easthesia of general an estimative complementation of successful compromentation of successful compromentation of successful compromentation of successful compromentation of successful compressions.	Surgical procedures must be performused providers who:  Are licensed to perform such procedures to organization is located Have been granted clinical privileg governing body, in accordance with appropriate and current health current prescription and non-press available, physical examination, a studies incorporated into the patie or according to local or state requesurgeny/procedure.  The use and timeliness of adminitional antibiotics is monitored to ensure or according to local or state reproving to and after a procedure are proving to a surgeny/procedure or beneform and are available in sufficient nurceare provided.  Each operating room is designed surgent operating room is available for surgens provided.  Each operating room is available for surgensemt in an operating room, and in compliance with applicable stat in compliance with applicable stat wills in basic cardiac life support.  If moderate sedation/analgesia, de anesthesia or general anesthesia courrently trained in advanced card documentation of successful componyle advanced resuscitative teams provide advanced resuscitative teams.	отпеd in a safe manner only by qualified SC The procedure was performed in a safe manner by a physician who was properly educated, credentialed and privileged.	redures within the state in which the SC Endoscopists are all properly licensed by the state.	leges to perform those procedures by the SC All physicians are properly credentialed and privileged to perform the procedures in the center.	th history must be completed, with a list of scription medications and dosages, when and pertinent pre-operative diagnostic tient's clinical record within thirty (30) days, quirement, prior to the scheduled	nistration of appropriate pre-operative NA Antibiotics not indicated for routine colonoscopy.	ation or resumption of medications prior SC Discharge instructions are thorough and complete.	of the proposed surgery, as well as any SC Patient is presented with all if any options prior to having procedure hingues have been discussed with the performed.	alth care professionals assisting in the SC The procedure room was adequately staffed with qualified personnel. Appropriately trained and supervised, horses for the surgical and emergency	and equipped so that the types of red in a manner that protects the lives red in a manner that protects the lives are an expension in the area. At least one gery. Only nonflammable agents are the room is constructed and equipped to an experimental endinged to the room is constructed and equipped to a single red for a single red for a machine.  There is an oxygen source (compressed oxygen with H cylinder back-up) and suction, as well as a meant to provide positive pressure ventilation. Piped in oxygen were present at each satellite.	patient contact maintain at a minimum SC All the staff maintains ACLS and BLS certification.	deep sedation/analgesia, regional is is provided, health care professionals and appropriate privileging to rechricular are present until all patients.
		Surgical procedures must be performed in a safe manner only by qualified providers who:	Are licensed to perform such procedures within the state in which the organization is located	Have been granted clinical privileges to perform those proce governing body, in accordance with Chapter 2, subchapter II	An appropriate and current health history must be completed, with a list of current prescription and non-prescription medications and dosages, when available, physical examination, and pertinent pre-operative diagnostic studies incorporated into the patient's clinical record within thirty (30) days, or according to local or state requirement, prior to the scheduled surgeny/procedure.	The use and timeliness of administration of appropriate prantibiotics is monitored to ensure maximum effectiveness.	Specific instructions for discontinuation or resumption of medications prior to and after a procedure are provided to the patient.	The necessity or appropriateness of the proposed surgery, as well as any available alternative treatment techniques have been discussed with the patient prior to scheduling for surgery.	Registered nurse(s) and other health care professionals assisting in the provision of surgical services are appropriately trained and supervised, and are available in sufficient numbers for the surgical and emergency care provided.	Each operating room is designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and ensures the physical safety of all persons in the area. At least one operating room is available for surgery. Only nonflammable agents are present in an operating room, and the room is constructed and equipped in compliance with applicable state and local fire codes.	All clinical support staff with direct patient contact maintain at a minimum skills in basic cardiac life support (BLS).	If moderate sedation/analgesia, deep sedation/analgesia, regional anesthesia or general anesthesia is provided, health care professional currently trained in advanced cardiac life support (ACLS), with documentation of successful completion and appropriate privileging to provide advanced resuscitative techniques, are present until all patient

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	PALS and age-and size-appropriate resuscitative equipment must be available at all times until all pediatric patients operated on that day have been physically discharged. Initial ACLS and PALS training and subsequent retraining shall be obtained from the American Heart Association or another vendor that includes "hands-on" training and skills demonstration of airway management and automated external defibrillator (AED) use.		
¥	Health care professionals trained in the use of emergency equipment and BLS must be available whenever there is a patient in the facility. At least one (1) physician or dentist is present or immediately available by telephone whenever patients are physically present in the facility.	SS	There is always at least 1 physician present while any patient is still in the center. There is also a CRNA present until the last patient is suitable for discharge.
_	With the exception of those tissues exempted by the governing body after medical review, tissues removed during surgery are examined by the pathologist, whose signed report of the examination is made a part of the patient's record.	SC	The tissue is examined by the pathology office at the north satellite for the center. If the patent's insurance will not cover on site path, the tissue is sent to an outside pathology company for evaluation.
Σ	The findings and techniques of a procedure are accurately and completely documented immediately after the procedure by the health care professional who performed the procedure. This description is immediately available for patient care and becomes a part of the patient's record.	SC	Full operative report with pictures and techniques are present in the medical record.
z	A safe environment for treating surgical patients, including adequate safeguards to protect the patient from cross-infection, is ensured through the provision of adequate space, equipment, supplies and personnel.	SC	There is a clear demarcation between clean and dirty areas. Endoscopes are removed for cleaning immediately after their use.
N-1	Provisions have been made for the isolation or immediate transfer of patients with a communicable disease.	SC	There is a policy in place that does not allow for patients for communicable diseases to be cared for at the center. The health department will also be notified.
N-2	All persons entering operating or procedure rooms are property attired as defined by the organization's written policy.	sc	This is not a sterile procedure. Endoscopists were dressed in professional attire with a cover gown.
N-3	Acceptable aseptic techniques are used by all persons in the surgical area.	SC	Hands are washed between cases. Waterless hand sanitizers are present throughout the center.
4 N	A written policy outlines the appropriate and timely surgical hand antisepsis (scrub) using either an antimicrobial soap or an alcohol-based hand rub according to product manufacturer's recommended guidelines.	sc	Hand washing policy is present and signage is present throughout the center regarding the importance of hand hygiene.
N-5	Only authorized persons are allowed in the surgical or treatment area, including laser rooms.	SC	Each room on has required personnel.
N-6	Suitable equipment for rapid and routine sterilization is available to ensure that operating room materials are sterile.	N A	The scopes are cleaned and sterilized in solution. There is no autoclave needed for anything used in the center.
N-7	Sterilized materials are packaged and labeled in a consistent manner to	NA A	Scopes are cleaned and disinfected. All other supplies used are

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	maintain sterility and identify sterility dates.		disposable.
8-N	Environmental controls are implemented to ensure a safe and sanitary environment.	sc	
6-N	Freshly laundered attire is donned in an area inside of the organization prior to entry into areas designated as restricted	NA	The area is not sterile. The nurses and techs wear scrub suits and the endoscopists are dressed in professional attire with a cover gown.
N-10	Attire used for personal protective equipment (PPE) or attire contaminated with blood or body fluid is laundered by a laundry that adheres to CDC or other nationally recognized guidelines and is approved by the organization	SC	
N-11	As needed to minimize the potential contamination of the surgical environment and surgical staff, patient clothing is removed or covered prior to the patient's entry into a surgical area.	sc	All personnel in the operative area wear scrubs and/or cover gowns that are changed between cases.
N-12	Measures are implemented to prevent skin and tissue injury from chemicals, cleaning solutions and other hazardous exposure, and to minimize the risk of fire	SC	
N-13	Policies are in place for pre-procedure site antisepsis, as appropriate to service(s) provided and patient requirements and needs.	NA	There is no sterile prep utilized for upper endoscopies or colonoscopies.
0	Suitable equipment for rapid and routine sterilization is available to ensure that operating room materials are sterile. Sterilized materials are packaged, labeled and stored in a consistent manner to maintain sterility and identify sterility dates.	NA	
0-1	The processes for cleaning and sterilization of supplies and equipment adhere to manufacturer's instructions and recommendations.	SC	Scopes are cleaned and disinfected according to the manufacturers suggested methods.
0-2	Internal and external indicators are used to demonstrate the safe processing of items undergoing high level disinfection and sterilization.	W <sub>A</sub>	
۵	Reprocessing of single-use devices must comply with FDA guidelines, and the devices must have been cleared under the FDA 510(k) process. Policies must clearly dictate the cleaning and handling of these devices in-house before sending them out for reprocessing. A written log must be maintained on all reprocessed devices.	N A	
Ø	Organizations that perform procedures where blood loss and subsequent blood replacement is a potential, have policies and procedures to address this type of situation and/or need.	Ā	
œ	Alternate power adequate for the type of surgery performed is available in operative and recovery areas.	SC	

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Ø	ā	Periodic calibration and/or preventive maintenance of equipment is provided.	SC	All equipment is maintained according to manufacturers recommendations and a log is kept.
F		The informed consent of the patient or, if applicable, of the patient's representative, is obtained before the procedure is performed.	PC	The patient signed a consent for anesthesia and a separate consent for the procedure but the risks and benefits were not reviewed with patient verbally prior to commencing the procedure.
ח		The organization utilizes a process to identify and/or designate the surgical procedure to be performed and the surgical site, and involves the patient in that process. The person performing the procedure marks the site. For dental procedures, the operative tooth may be marked on a radiograph or a dental diagram.	NA	
>		Immediately prior to beginning a procedure, the operating team verifies the patient's identification, intended procedure, and correct surgical site, and that all equipment routinely necessary for performing the scheduled procedure, along with any implantable devices to be used, are immediately available in the operating/procedure room. The provider performing the procedure is personally responsible for ensuring that all aspects of this verification have been satisfactorily completed immediately prior to beginning the procedure.	SC	A time out was performed prior to commencing the procedure, This is the routine for the center.
>		The organization has a procedure to address when sponge, sharps and instrument counts will occur, the items that will be counted, and the types of procedures requiring counts, when applicable. When appropriate, there is a process to ensure that counts are done before and after the procedure.	NA	
×		A process is in place for the observation, care and communication of such care in all peri-procedural areas of the patient's facility experience. The organization must define and implement a process in which information about the patient's care is communicated consistently. The process must include means to educate the staff and medical care providers about the process and support implementation consistently throughout the organization.	SC	
>		The organization follows established protocols for instructing patients in self-care after surgery, including the provision of written instructions to patients who receive moderate sedation/analgesia, deep sedation/analgesia, regional anesthesia or general anesthesia.	SC	Patients are given verbal instruction prior to discharge as well as written instructions.
		Standard Z will be applied to organizations that provide surgical, diagnostic and/or therapeutic services to children.		
Z		A safe environment for treating pediatric surgical patients is assured through the provision of adequate space, equipment, supplies, medications and personnel.	NA V	The center does not care for pediatric patients.
A.A		Organizations that receive/store/issue blood and blood products for	¥	

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	Consultative Comments
transfusion or human cells or tissues for transplantation must have written protocols for handling, maintenance and storage, consistent with those of a nationally-recognized authority, such as the American Association of Tissue Banks (AATB) and the U.S. Food and Drug Administration (FDA).	Consultative Comments

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Chapter	10 - Surgical	Chapter 10 - Surgical and Related Services - Laser and Light-Based Technologies II	echnologi	Si
Standard	CMS		Compliance Rating	Соттепts
		Chapter 10 - Surgical and Related Services		
		Subchapter II - Laser, Light-Based Technologies and Other Energy-Emitting Equipment: This subchapter addresses surgery or procedures that involve laser, light-based technologies or other energy-emitting equipment.	SC	There is a YAG laser present which is rarely used for cautery of Barrett's Esophagus.
A		Policies and procedures should be established and implemented for these devices, which include, but are not limited to:	SC	There is a specific polity in place in the Policy and Procedure Manual for the use of the laser.
A-1		Safety programs	sc	All the staff that utilizes the laser undergo an annual educational meeting led by a bio engineer. His credentials to teach the safe use of lasers is included in the centers paperwork.
A-2		Education and training of personnel, including a requirement for all personnel working with these devices to be adequately trained in the safety and use of each type of device utilized in patient care.	၁ၭ	There are annual educational meetings regarding safe laser use.
В		The organization ensures that its facility is a safe environment, including:	sc	
P-1		Granting privileges for each specific device	sc	Each physician who utilizes the laser is properly privileged.
B-2		Ensuring that only authorized persons are allowed in treatment areas	SC	As part of the policy, only necessary personnel are present in the laser room when it is in use.
B-3		Utilization of door and window coverings, where appropriate	sc	Wooden door and covered windows are present in the laser room.
B-4		Prominently displayed warning signs being present only during procedures at the entrance to treatment areas	sc	LASER in use sign is mounted on the door with velcro and removed when not being used.
B-5		When necessary, utilization of protective eyewear by personnel in treatment areas as recommended by the device manufacturer.	SC	Eye wear is present in the room and donned when the LASER is in use.
B-6		When appropriate, utilization of smoke evacuators and utilization of appropriate devices to control tissue debris, high filtration masks and/or wall suction with filters to minimize laser plume inhalation	sc	Suction is present.
B-7		Utilization of appropriate disinfectant or sterilization of components that have direct patient contact	SC	All reusables are thoroughly cleaned, and disposables are utilized when feasible.

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B-8	Enst	Ensuning appropriate fire protection, including:	SC	
B-8a	The	The immediate availability of electrical-rated fire extinguishers for equipment fires	SC	Fire extinguisher is present in the LASER room as is Saline.
B-8b	The imm igniti	The maintenance of a wet environment around the operative field and the immediate availability of an open container of saline or water where ignition of flammable materials is possible	SC	The use of wet towels around the surgical site is implemented.
B-8c	The	The use of safe equipment and/or techniques, especially for procedures in and around the airway	sc	All machinery is used for its intended purposes and is maintained according to manufacturers recommendations.
B-8d	The	The utilization of non-combustible materials, supplies, and solutions as appropriate	sc	Only non combustible materials are utilized.
B-8e	Thai shot shift	That drape material is not positioned in front of the laser beam; drapes should be checked prior to use of laser to ensure that material has not shifted during the procedure	SC	
B-9	Doc	Documenting that maintenance logs are present that confirm the inspection and testing of these devices	SC	Preventative maintenance logs are present and were evaluated.
O	The	The organization ensures patient safety, including:	sc	
C-1	Assi man the /	Assurance that procedures are done in accordance with device manufacturer's guidelines and are consistent with the current version of the ANSI Standard for Safe Use of Lasers in Health Care Facilities	SC	The LASER is only used for its intended FDA approved reasons and is utilized using standard practice,
C-2	Prot	Protection of the patient's eyes, skin, hair and other exposed areas	sc	Patient is protected with wet towels during the use of the LASER.
6-3	Mh∈   Wh∈	When available, the use of non-reflective surgical instruments and supplies	SC	
C4	App	Appropriate patient education regarding procedure risks and potential complications.	SC	Staff that uses the laser is well trained in its safe use,
	Con	Consultative Comments		Consultative Comments

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Standard CMS				
			Compliance Rating	Comments
	Chapter 11 - Pharmaceutical Services			
	Pharmaceutical services provided or made available by an accreditable organization meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.	ices provided or made available by an ation meet the needs of the patients and are nee with ethical and professional practices and Such an organization has the following		
	Overall Chapter Compliance Level		sc	
4	Pharmaceutical services are provided or made available in a safe and effective manner, in accordance with accepted professional practice and under the direction of an individual designated responsible for pharmaceutical services in accordance with Standard 11.J.	made available in a safe and repted professional practice and inated responsible for with Standard 11.J.	SC	There is one nurse responsible for ordering and maintaining pharmacy stock. There is a outside pharmacist contracted that oversees all pharmacy quarterly.
В	Pharmaceutical services are provided in accordance with ethical and professional practice and applicable federal and state laws.	accordance with ethical and srale laws.	SC	Pharmacy is maintained in a secure and ethical fashion.
v	Staff demonstrates knowledge of applica pharmaceutical laws.	of applicable state and federal	SC	Staff was aware of how drugs need to be checked for expiration dates routinely and how controlled substances need to be stored and dispensed.
Q	Records and security are maintained to ensure the control and safe dispensing of drugs, including samples, in compliance with federal a state laws.	itained to ensure the control and safe samples, in compliance with federal and	sc	All prescription non-narcotic drugs are stored in a secure fashion and are within expiration date.
В	Staff informs patients concerning safe and effective use of medications consistent with legal requirements and patient needs.	nd effective use of medications atient needs.	SC	Patients are given instruction as to how to use prescribed medications.
ш	Measures have been implemented to ensure that prescription pads are controlled and secured from unauthorized patient access, and pre-signed and/or postdated prescriptions pads are prohibited.	nted to ensure that prescription pads are nauthorized patient access, and pre-signed pads are prohibited.	sc	Prescription pads are locked in the narcotic lock box. There were no pads present in the lock box since all prescriptions are done electronically.
O	All medications, including vaccines and samples, are checked for expiration dates on a regular basis; expired items are disposed of in a manner that prevents unauthorized access, protects safety, and meets state and federal requirements.	samples, are checked for red items are disposed of in a sss, protects safety, and meets	SC	The drugs are checked monthly for expiration. All boxes were labeled clearly with their expiration dates.
I	All injectable medications drawn into syringes and oral medications removed from the packaging identified by the original manufacturer must be appropriately labeled if not administered immediately.	wn into syringes and oral medications dentified by the original manufacturer must administered immediately.	သွ	All syringes drawn up were labeled.

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<u></u> 5	The organization must have policies in place for safe use of injectables and single-use syringes and needles that at minimum include the CDC or comparable guidelines for safe injection practices.	SC	All personnel responsible for injecting meds are credentialed to do so. This is done within the guidelines of the CDC.
٦	Pharmaceutical services provided by the organization are directed by a licensed pharmacist or, when appropriate, by a physician or dentist who is qualified to assume professional, organizational and administrative responsibility for the quality of services rendered.	SS	There is a contract in place with an outside pharmacist who visits all center locations quarterly.
¥	Providers or other health care professionals who prescribe, dispense, administer and provide patient education on medications have easy access to current drug information and other decision support resources.	SC	
7	If look-alike or sound-alike medications are present, the organization identifies and maintains a current list of these medications and actions to prevent errors are evident.	SC	There is a policy in place defining the look alike, sound alike drugs.  These are stored separately from each other.
Σ	Procedures are established by the organization for maintenance, cleaning, distribution and use of devices such as nebulizer units, intravenous infusion pumps or any other mechanical device used in the medication delivery process.	₹ Z	
z	A pharmacy owned or operated by the organization is supervised by a licensed pharmacist.	Ą.	There is no pharmacy on site.
0	Pharmaceutical services made available by the organization through a contractual agreement are provided in accordance with the same ethical and professional practices and legal requirements that would be required if such services were provided directly by the organization.	SS	
۵	Patients are not required to use a pharmacy owned or operated by the organization.	NA	Patients are given prescriptions and may use any pharmacy.
	Consultative Comments		Consultative Comments

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Chapter	12 - Patholog	Chapter 12 - Pathology and Medical Laboratory Services - CLIA Waived Tests I	d Tests I	
Standard	CMS		Compliance Rating	Comments
		Chapter 12 - Pathology and Medical Laboratory Services		
		Pathology and medical laboratory services provided or made available by an accreditable organization meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.		
		Overall Chapter Compliance Level	SC	
		Subchapter I - CLIA-Waived Tests: This subchapter applies only to health care organizations providing services that meet the Clinical Laboratory Improvement Amendments (CLIA) of 1988, requirements for waived tests.	SC	The center has a CLIA waiver in place and performs only glucose testing.
4		An accreditable organization:	SC	
A-1		Meets the requirements for waived tests under CLIA (part 493 of Title 42 of the Code of Federal Regulations) if it performs its own laboratory services, performs only waived tests, and has obtained a certificate of waiver, and/or	SC	CLIA waiver is in place for each center.
A-2		Has procedures for obtaining routine and emergency laboratory services from a certified laboratory in accordance with CLIA if it does not perform its own laboratory services	sc	There is a contract in place with Path Group Lab for any lab testing that is required.
В		Pathology and medical laboratory services provided or made available are appropriate to the needs of the patients and adequately support the organization's clinical capabilities.	sc	All indicated labs are available.
O		Pathology and medical laboratory services include, but are not limited to:	sc	
2		Conducting laboratory procedures that are appropriate to the needs of the patients	SC	The only laboratory testing at the center is glucose testing. All other needed labs are available.
C-2		Performing tests in a timely manner	SC	Tests are performed in a timely fashion and are quickly available in the medical record.
53		Distributing test results after completion of a test and maintaining a copy of the results	sc	All labs are stored in the patient's electronic medical record.

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2	Performing and documenting appropriate quality control procedures, including, but not limited to, calibrating equipment periodically and validating test results	sc	Controls are performed in accordance with the manufacturer recommendation and logs are kept.
C-5	Ensuring that staff performing tests has adequate training and competence to perform the tests.	SC	There is an educational session given to all personnel who will be performing the tests and competency is evaluated
Q	The organization has a policy that ensures that test results are reviewed appropriately and that documents that test results are reviewed by the ordering physician or another privileged provider.	sc	All labs are signed off by the ordering physician.
	Consultative Comments		Consultative Comments

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Summary Table	Overall Chapter Level
1. Rights of Patients	sc
2. Governance	sc
I. General Requirements	sc
II. Credentialing and Privileging	sc
3. Administration	sc
4. Quality of Care Provided	SC
5. Quality Management and Improvement	SC
I, Peer Review	SC
II. Quality Improvement Program	SC
III. Risk Management	sc
6. Clinical Records and Health Information	SC
7. Infection Prev	SC
I. Prevention and Control	SC
II. Infection Safety	SC
8. Facilities and Environment	SC
9. Anesthesia Services	SC
10. Surgical and Related Services	SC
I. Surgical - General	SS
II. Surgical - Laser	SC
11. Pharmaceutical Services	SC
12. Pathology and Medical Laboratory Services	SC

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I. CLIA-Waived Tests	SC
II. CLIA-Laboratories	NA
13. Diagnostic and Other Imaging Services	W
14. Dental Services	M
I. Dental Services	NA
II. Dental Home	NA
15. Other Professional & Technical Services	NA
I, General Services	NA
II, Travel Medicine	NA
16. Health Education and Health Promotion	NA
17. Behavioral Health	W
18. Teaching and Publication Activities	NA.
19. Research Activities	NA
20. Overnight Care and Services	NA
21. Employee and Occupational Health Services	NA.
22. Immediate/Urgent Care Services	NA
23. Emergency Services	NA
24. Radiation Oncology Treatment Services	NA
25. Managed Care Organizations	NA
26. Lithotripsy	NA
27. Medical Home	NA

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**Miscellaneous Information** 

#### THE ENDOSCOPY CENTER OF KNOXVILLE, THE ENDOSCOPY CENTER NORTH, THE ENDOSCOPY CENTER WEST

Approved Procedure List

#### **PROCEDURES**

PROCEDURES	-
AIRWAY TECHNIQUES	
Emergency Cricothyrotomy	
Intubation	
Mechanical Ventilation	
ANESTHESIA	
Supervision of CRNA's	
Moderate Sedation ("conscious	
sedation")	
Deep Sedation w/Propofol	
Supervision of RN administered	
Moderate Sedation	
DIAGNOSTIC PROCEDURES	
ANOSCOPY	
COLONOSCOPY	
w/Biopsy/Cytology	
w/Foreign Body Removal	
w/Polyp Removal	
wW/Tumor Ablation	
For Control Hemorrhage	
Through Colostomy	
EGD	
w/Biopsy/Cytology	
w/Foreign Body Removal	
w/Sclerotherapy	
wW/Tumor Ablation	
For Control Hemorrhage	
w/Ph Monitoring (Bravo)	
ESOPHAGEAL DILITATION	
Maloney	
w/Guidewire	
w/Balloon	
ESOPHAGOSCOPY	
w/Biopsy/Cytology	
w/Foreign Body Removal	
w/Polyp Removal	
w/Sclerotherapy	
Injection Therapy	
Tumor Ablation	
ENDOSCOPIC ULTRASONOGRAPHY	
(EUS)	
FINE NEEDLE ASPIRATION (FNA)	
ERCP	
SPHINCTEROTOMY	

#### **PROCEDURES**

FLEXIBLE FIBERSIGMOIDOSOCPY	
w/Biopsy/Cytology	
w/Foreign Body Removal	
w/Polyp Removal	
For Control Hemorrhage	
w/Tumor Ablation	
ILEOSCOPY	
w/Biopsy/Cytology	
Through Stoma	
LASER PHOTOCOAGULATION	
LIVER BIOPSY	
PARACENTESIS	
PEG REMOVAL/REPLACEMENT	
RIGID SIGMOIDOSCOPY	
w/Biopsy/Cytology	
SMALL BOWEL BIOPSY	
SMALL BOWEL ENTEROSCOPY	
w/Biopsy/Cytology	
w/Polyp Removal	
For Control Hemorrhage	
EMR	
BARRx	
STRICTUROTOMY	
HEMORRHOID BANDING	
INTERSTIM PROCEDURE	
ENDOBARRIER THERAPY	
FECAL MICROBIAL TRANSPLANTAT	

Revised March 2015



9 April 1/, 2013

Administrator
Gastrointestinal Associates, PC and The Endoscopy Center
801 Weisgarber Road, Suite 100
Knoxville, TN 37901

Re:

Transfer Agreement

Dear Sir or Madam:

Enclosed are two (2) originals of a Transfer Agreements between Metro Knoxville HMA, LLC d/b/a Tennova Healthcare – Physicians Regional Medical Center and Gastrointestinal Associates, PC and The Endoscopy Center. Please review and obtain the appropriate signatures on behalf of Gastrointestinal Associates, PC and The Endoscopy Center and return the signed agreements to me for signature on behalf Metro Knoxville HMA, LLC d/b/a Tennova Healthcare – Physicians Regional Medical Center. I will then obtain those signatures and return one (1) fully executed original agreement to you for your file.

Thank you for your assistance with the completion of these agreements. If you have any questions, please call me at 865/545-7541.

Sincerely,

Deon Cabbage

**Executive Assistant** 

lon Callage

Encl.

## **CONTRACT REVIEW SUMMARY SHEET**

Facility Name: Physicians Regional Medical Center												
.ndor/Physician:	Gastro	ointestir	ıal A	Associ	ates	, PC a	nd The Endos	scopy Center	•			i
Service Provider:	Trans	fer Agre	em	ent						MMEN		
Effective Date: 5/1/13	3 E	xpiration	Dat	e: ur	ıtil te	rminate	d	Purpose of this to transfer pati				
Termination Clause:	30 days	advance	writt	en notic	е			benefit from the				
Automatic Renewal?	Ye	s 1	No	x N/A	L	ength:	until terminated		Daniel Control			
If not renewed, what d	ate to be	cancele	d by					HMA Templa	te used.			
Terms: effective 4/1/12	2 and co	ntinues u	ntil t	erminat	ed b	y either	party upon					×
30 days advance writte	en notice	•										
Payment Terms (Days	of weel	, month,	etc.,	how of	ten?	): N/A						
Contract Status: x	New	R	enev	val								
Current Number of Co	vered Li	ves: N/A						[				
Annualized Volumes S	Seen: N	'A										
Insurance Required?		Yes		No	х	N/A	Amount:					
,dit Required?								Yes		No	x	N/A
Is Certification Evidence	cing Cov	erage Cu	irren	it?				Yes		No	х	N/A
Does Contract Have "	Save Ha	rmless" C	laus	se?				Yes		No	х	N/A
Allow for recovery of R Limitations?	Reimburs	ement Lo	oss I	Due to N	/ledic	care		Yes		No	х	N/A
Does Contract Contain	Open F	Records F	rovi	sion?				Yes		No	х	N/A
Is Proof of Licensor of	Accredi	tation Pro	vide	d?				Yes		No	х	N/A
is Party Responsibility	for Bill S	Services I	Defir	ned?				Yes		No	х	N/A
Is National Practitione	r Data B	ank (NPC	)B) /	Attached	i			Yes		No	x	N/A
		0	CO	NTRA	CT F	REVIE	W AND APPR	ROVAL		-7		
CNO: Sue Beauregar	d A	ere 1	3	ecen	وسري	co Cen	-0		Date;	3/20/	3_	
CFO: Rhonda Mayna	rđ:	ĺ	RH	al	M	ne			Date:	29/17		
Hospital CEO/COO: k	Karen Me	etz		Nape	n (	Wet	>		Date:	41-1	3	
Is Corporate Review/A	pproval	needed:	ΠY	es DNo	lf Y	(ES, pls	indicate:   Leg	al Gary Link				
Legal Counsel:									Date:			



Search Results

No results were found for GastroIntestinal Associates, PC; The Endoscopy Center;

Search conducted 3/20/2013 7:58:37 AM EST on OIG LEIE Exclusions database.
Source data updated on 3/7/2013 8:50:07 AM EST



Forces Username? Forgot Passivered

Create an Assessal

HOME SEARCH RECORDS DATA ACCESS GENERAL INFO

### Search Results

You can refine your search by entering new search criteria in the search box and using the Search In Results button. If you wish to perform a new search use the Clear Search button. Using the Save Search button will allow you to run this search at a later time. Important message regarding exclusion searches,

### Current Search Terms: gastrointestinal\* associates\* PC

Clear Search



### FILTER RESULTS

No records found for current search.

By Record Status

Active

Inactive

By Functional Area

Erikty Hanagement

Performance Information



Forgot Username?

Forgot Passuce (1)

Create an Account

HOME SEARCH RECORDS DATA ACCESS

GENERAL INFO

Search Results

You can refine your search by entering new search chiefra in the search box and using the Search In Results button, If you wish to perform a new search use the Clear Search button. Using the Save Search button will allow you to run this search at a later time. Important message regarding exclusion searches,

Current Search Terms: The\* endoscopy\* center\*

Clear Search

Result page 1 of 1 Order by Ascending	STATE FOR DECEMBER 1	nistante   ermi
FILTER RESULTS	Your search for "The" Endoscopy* Center" returned the following	
Bu Bassad States	results	

Active

Inacove

Entity

YUMA AZ EHDOSCOPY ASC, LLC, THE

DLVIS: 032078177 Has Active Evolusion?: No CAGE Code: 4Y9AZ

DoDAAC:

View Details

Status: Active!

By Functional Area

Enbly Management

Performence Information

### PATIENT TRANSFER AGREEMENT

THIS PATIENT TRANSFER AGREEMENT ("Agreement") is made as of May 1, 2013, between Gastrointestinal Associates, PC and The Endoscopy Center ("Transferring Facility") and Metro Knoxville HMA, LLC d/b/a Tennova Healthcare – Physicians Regional Medical Center ("Receiving Facility").

### WITNESSETH

WHEREAS, the parties desire to: facilitate the timely transfer of patients who require acute care inpatient hospital services ("Patients") as well as medical and other information necessary or useful in the care and treatment of the Patients;

WHEREAS, the parties desire to: expedite decisions as to the most appropriate provider of care for Patients; ensure them continuity of care and treatment required by Patients; and improve the professional health care provided to Patients by utilizing the knowledge and other resources of both parties in a coordinated and cooperative manner;

WHEREAS, Transferring Facility must arrange to transfer Patients to other facilities;

WHEREAS, the Receiving Facility has agreed to accept transfer of Patients under the terms set forth herein;

WHEREAS, the parties desire to supply a full statement of their agreement with respect to the provision of services during the term of this Agreement.

NOW, THEREFORE, the parties agree as follows:

1. <u>Situations Justifying Transfer.</u> When beds and staff are available and the applicable provisions of this Agreement are observed, Receiving Facility agrees to accept Patients in need of medical care that is not available at Transferring Facility. The procedure for transfer is as follows: Call 865/545-7573 and inform the Receiving Facility of the nature of the transfer.

### 2. Receiving Facility Agrees:

- A. To accept the transfer of Patients from Transferring Facility who meet admission criteria, subject to the availability of beds.
- B. To comply with all provisions of EMTALA and HIPAA/HITECH.
- C. That no emergency transfer will be delayed for financial reasons.

### 3. Transferring Facility Agrees:

- A. To identify Patients and to obtain Receiving Facility's acceptance of the transfer prior to transferring the patient.
- B. To obtain the Patient's consent to the transfer if the Patient is competent. If the Patient is not competent, Transferring Facility shall obtain a family member's consent; if such consent is not possible, the consent of the Patient's physician shall be obtained by Transferring Facility.

- C. To work collaboratively with Receiving Facility to provide clinical information to ensure continuity of care in compliance with EMTALA regulations and insofar as confidentiality laws permit.
- D. To comply with all provisions of EMTALA and HIPAA/HITECH.
- E. To arrange for transportation from the Transferring Facility to Receiving Facility.
- 4. <u>Patient Records and Personal Effects.</u> Transferring Facility shall use standard forms to provide medical and administrative information to accompany the patient to Receiving Facility. The information shall include, when appropriate, the following:
  - A. Patient's name, address, hospital number, age, and name, address and telephone number of next of kin if available;
  - B. Patient's third party billing data;
  - C. History of the illness;
  - D. Condition on admission:
  - E. Vital signs pre-hospital, during stay in the emergency department, and at the time of transfer;
  - F. Treatment provided to patient, including medications given and route of administration;
  - G. Laboratory and X-ray findings;
  - H. Fluids given, type and volume;
  - I. Name, address, and phone number of physician referring patient;

Transferring Facility shall supplement the above information as necessary for the maintenance of the Patient during transport and as necessary for treatment upon arrival at Receiving Facility. In addition, the inventory of the Patient's personal effects and valuables shall accompany the patient during transfer. The records described above shall be placed in the custody of the person in charge of the transportation medium who shall sign a receipt for the medical records and the Patient's valuables and personal effects and shall in turn shall obtain a receipt from Receiving Facility when it provides the records and the Patient's valuables and personal effects to Receiving Facility.

- 5. Independent Contractor Status. Each of the institutions are independent contractors. Neither of the parties is authorized or permitted to act as an agent or employee of the other. Nothing in this Agreement shall in any way alter the freedom enjoyed by the parties, nor shall it in any way alter the control of the management, assets, and affairs of the respective parties. Neither party, by virtue of this Agreement, assumes any liability for any debts or obligations, of either a financial or legal nature, incurred by the other party to this Agreement.
- 6. <u>Insurance</u>. Each Party shall secure and maintain, or cause to be secured and maintained, during the term of this Agreement comprehensive general and professional liability insurance.

7. Renegotiation or Modification. Any alterations, variations, modification or waivers of any provision of this Agreement shall only be valid when they have been reduced to writing and duly signed. The parties agree to renegotiate this Agreement if there are changes to Federal and/or State law, regulations, or the interpretation thereof make amendments to this Agreement necessary in the judgment of either party.

### 8. Term and Termination.

- A. This agreement shall commence on May 1, 2013 and continue in effect until terminated by either party.
- B. Either party may terminate this Agreement or any part of this Agreement at any time, upon no less than 30 days notice in writing to the other party. Said notice shall be delivered by certified mail, facsimile transmission, or in person.
- No Exclusion from Programs. Each party represents that neither it nor its employees are currently excluded from participating in any federal or state government-funded health care program.
- 10. <u>Books and Records.</u> The parties agree that to the extent this Agreement is subject to the provisions of Public Law 96-449, the Omnibus Reconciliation Act of 1980, they will make available all books and records with respect to the services provided to the extent required by law; and to the extent required by law, the provisions of Section 1395x(v)(1) of Title 42 of the United States Code are incorporated herein by reference with like effect as though set forth at length.
- 11. <u>Governing Law.</u> This Agreement is made and entered into in the State of Tennessee and shall be governed and construed in accordance with the laws of Tennessee.
- 12. <u>Assignment.</u> This Agreement shall not be assigned in whole or in part by either party hereto without the express written consent of the other party.
- 13. <u>Invalid Provision</u>. In the event that any portion of this Agreement shall be determined to be invalid or unenforceable, the remainder of this Agreement shall be deemed to continue to be binding upon the parties hereto in the same manner as if the invalid provision were not a part of this Agreement.
- 14. <u>Notice</u>. All notices required or permitted pursuant to this Agreement shall be in writing and delivered by certified U.S. mail, postage prepaid, return receipt requested, and shall be deemed effective two (2) business days after mailing, if addressed to the parties at the following addresses:

If to Transferring Facility:

Gastrointestinal Associates, PC and

The Endoscopy Center

801 Weisgarber Road, Suite 100 Knoxville, Tennessee 37901 Attn: Administrator

If to Receiving Facility:

Metro Knoxville HMA, LLC d/b/a Tennessee

Healthcare - Phylisicians Regional Medical

Center

900 E. Oak Hill Avenue

Knoxville, Tennessee 37917

Attn: CEO

15. Binding Agreement. This Agreement shall be binding upon the successors or assigns of the parties hereto.

- 16. Authorization for Agreement. The execution by each party has been duly authorized by all necessary laws, resolutions, or corporate actions, and this Agreement contains the valid and enforceable obligations of each Party.
- 17. Headings. The headings to the various sections of this Agreement have been inserted for convenience only and shall not modify, define, limit or expand express provisions of this Agreement.
- 18. No Verbal Modifications. This Agreement may not be modified, amended, supplemented or waived except by written agreement, signed by the parties. No delay, omission or failure by a party to exercise any right, power or remedy to which a party may be entitled shall impair any other such right, power or remedy, nor shall such be construed as a release by a party of such right, power or remedy or as a waiver, unless set forth in a written agreement, signed by the parties. A waiver by a party of any right, power or remedy in any one instance shall not constitute a waiver of the same or any other right, power or remedy in any other instance.

IN WITNESS WHEREOF, Receiving Facility and Transferring Facility have hereunto caused this Agreement to be executed as by law provided, the day and year first above written.

**Receiving Facility** 

Signature

Karen Metz

Transferring Facility

Signature

Page 4 of 5

	Cryle Mahan
Printed Name	Printed Name
	administrato/
Title	Title

540		

# S Chip Report for April 2015

MCO	REGION	Total
AMERIGROUP COMMUNITY CARE		389,230
BLUECARE	East Tennessee	188,407
BLUECARE	Middle Tennessee	146,832
BLUECARE	West Tennessee	146,715
UnitedHealthcare Community Plan	East Tennessee	168,046
UnitedHealthcare Community Plan	Middle Tennessee	161,502
UnitedHealthcare Community Plan	West Tennessee	138,204
TENNCARE SELECT HIGH	All	49,418
TENNCARE SELECT LOW	All	10,348
Awaiting MCO assignment		305
Grand Total		1,399,007

Female         Female           604         9,172           620         12,53           139         2,232           139         1,738           656         12,533           656         12,533           656         12,533           656         12,373           656         12,373           656         12,373           656         12,373           153         2,220           153         2,247           153         2,247           153         2,624           211         2,548           212         2,684           438         6,124           3351         81,017           3351         81,017           3351         81,017           3351         3,254           3351         3,254           336         6,028           4,336         6,028           4,336         6,028           4,336         6,024           337         4,330           220         2,624           213         3,554           334         4,040	Female         0 - 18         19-18           Total         0 - 18         19-18           6,9,172         4,299         8,299           1,738         8,899         1,232           1,738         8,899         1,232           1,738         8,979         7,79           1,2,533         5,979         7,79           1,2,732         2,979         7,79           7,329         2,979         7,79           7,329         2,979         7,79           4,072         2,038         2,123           4,072         2,038         1,047           6,284         3,259         1,404           6,284         3,259         2,492           7,548         3,011         6,124           8,077         7,12         2,651           1,570         7,12         2,061           6,028         2,755         3,011           6,028         2,555         3,007           1,570         1,896         3,756           8,567         1,758         3,254           8,740         4,483         3,763           1,040         1,758         3,382           <	Female         Male           Total         0 - 18         19 - 20         21 - 21           1,728         4,299         280         1           6,993         3,849         280         1           1,738         889         62           12,553         5,909         87           12,373         5,973         213         1           12,373         5,973         213         1           12,373         5,973         213         1           1,691         779         67         4           7,407         3,272         216         1           4,072         2,038         129         1           2,253         1,044         69         6           2,253         1,044         69         1           6,342         2,123         175         1           1,570         3,257         199         1           6,284         3,567         199         1           1,570         1,209         124         1           6,028         2,755         224         1           1,570         1,404         2,05         1
	10000000000000000000000000000000000000	19 - 20   21 - 64     19 - 20   21 - 64     19 - 20   21 - 64     19 - 20   21 - 64     19 - 20   21 - 64     19 - 20   21 - 64     19 - 20   21 - 64     19 - 20   21 - 64     19 - 20   21 - 64     19 - 20   21 - 64     10 - 21   1,931     10 - 21   1,931     10 - 21   1,931     10 - 21   1,931     10 - 21   1,450     10 -

		remaje								_	
COUNTY	0-18	19 - 20	21 - 64	65>	Total	-	19 - 20	21 - 64	65 ->		Grand lotal
JACKSON	648	29	689	133	1,532	689	090	393	95	1,237	2,769
JEFFERSON	3,109	243	2,920	477	6,749	3,255	500	1,439	198	260'9	11,841
JOHNSON	926	106	1,081	278	2,441	,065	99	689	153	1,973	4,414
KNOX	19,329	1,510	19,172	2,413	42,424	20,195	1,153	8,281	1,074	30,703	73,127
	453	38	909	152	1,249	539	41	269	65	914	2,163
AUDERDALE	1,980	188	2,056	309	4,533	2,073	155	863	125	3,216	7,749
LAWRENCE	2,577	236	2,502	411	5,726	2,785	157	1,270	152	4,364	10,090
TEMIS	022	02	723	127	1,690	756	74	331	57	1,218	2,908
N JOSNI I	1.940	146	1.783	284	4,153	2,031	121	698	114	3,135	7,288
NOUTO	2 373	201	2.040	267	4,881	2.482	110	896	106	3.666	8.547
MACON	1 771	150	008	250	2 779	1 839	127	796	118	2878	6.657
NO.	1771	000	000,1	630	0,7,0	0001	1200	00000	230	2,010	22 202
MADISON	6,439	430	0,530	0.0	14,040	0,000	200	0000	353	00000	20000
MARION	1,761	174	1,889	236	4,060	1,784	119	828	671	7,860	6,920
MARSHALL	1,746	119	1,607	169	3,641	1,842	102	899	7.1	2,683	6,324
MAURY	4,834	333	4,453	529	10,149	5,085	270	1,728	189	7,272	17,421
NW	7 997	270	3.047	510	6.824	3.188	188	1,406	215	4.997	11,821
MCNARY	1 737	175	1 965	362	4.234	1.876	137	1.096	186	3,295	7,529
SOLO	763	02	791	85	1 709	810	58	408	43	1.319	3,028
200	2000	100	0 0 0 0	402	085.3	2 038	101	1 436	230	4 895	11 275
MOINTO	6,500	212	0,040	200	18,280	0000	451	2847	228	12 588	30.868
MONI GOMERT	9,112	200	0070	727	0070	2000	200	Co	31	378	824
MOOKE	607	000	0.1	Cr	2000	1020	000	202	00	2073	A 728
MORGAN	1,208	103	1,135	200	2,033	1,270	300	220	2117	2 150	7,570
OBION	4,984	1/4	2,063	167	4,512	2,03	000	740	- 000	0,100	0,0,0
OVERTON	1,204	138	1,223	597	2,830	1,315	1 13	6/0	130	0,540	0,0,0
PERRY	540	37	471	11	1,125	521	48	5/0	35	874	555
PICKETT	252	25	576	86	633	295	27	153	45	520	1,159
POLK	968	110	1,015	155	2,248	1,033	/9	531	(1	1,702	3,950
PUTNAM	4,149	346	4,135	717	9,347	4,313	269	2,169	320	7,071	16,418
RHEA	2,334	196	2,169	344	5,043	2,381	167	1,054	135	3,737	8,780
ROANE	2,604	230	2,971	512	6,317	2,894	178	1,573	219	4,864	11,181
ROBERTSON	3,798	286	2,990	366	7,440	Н	213	1,199	165	5,602	13,042
RUTHERFORD	13,264	1,051	11,070	975	26,360	-	744	3,946	413	18,886	45,246
SCOTT	1.871	166	2.019	381	4,437		124	1,095	191	3,397	7,834
SFOURTCHIE	866	85	666	142	2,224	1,018	74	532	52	1,676	3,900
CEVIED	5 394	413	4.574	458	10.839		311	1,878	163	8,131	18,970
SHE BY	74,119	5.729	66.348	6.764	152,960	1	4,911	21,455	2,797	104,912	257,872
SMITH	1,066	109	1.048	161	2,384		59	482	64	1,697	
CTEWART	722	000	767	114	1,661		49	381	52	1,243	2,904
CILLIVAN	7,791	7007	8.568	1.281		L	538	4.225	561	13,589	
CHIMNED	7,697	E03	7.012	768	16,080	8.025	462	2.731	310	11,528	
TIOTOTI	2000	331	3 370	370			285	1,279	132	5.489	l
TECHNICATION	1000	62	481	69	1134	4RR	46	225	33	792	1
TROUGOS	030	20	200	252	2 273		707	470	119	1,692	
ONCO.	1363	100	1 170	150	2824		03	672	87	2 146	
	210	22	320	200	728		24	176	48	588	
VAN BUKEN	0000	700	350	422	03.0		160	1 252	194	4 552	10 702
KAREN	010/2	197	0303	047	12 200		367	2 896	422	9 449	
WASHINGLON	0,000	00+	928	185	1 867	842	08	419	7.1	1 412	
WEAKIEV	1 798	182	1 942	311	4 233	L	132	926	107	3.024	7,257
WICHE	1720	150	1711	304	3.885		118	927	123	2,992	6,877
WILLIAMSON	3.185	206	2.548	368	6.307	3.322	201	1,022	141	4,686	£.
NOS IIM	4.896	359	4.484	467	10,206		271	1,789	190	7,324	
Other	2,481	245	2,773	117	5,616		164		82		2/9'6

Reports include some membership additions that are the result of retroactivity; however, additional retroactivity may still occur. The "Other" county category reflects recipients who are Tennessee residents for which their domicile is temporarily located outside of the state.

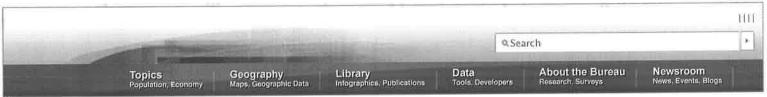
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State & County QuickFacts

## **Anderson County, Tennessee**

People QuickFacts	Anderson County	Tennessee
Population, 2014 estimate	75,528	6,549,352
Population, 2013 estimate	75,494	6,497,269
Population, 2010 (April 1) estimates base	75,126	6,346,275
Population, percent change - April 1, 2010 to July 1, 2014	0.5%	3.2%
Population, percent change - April 1, 2010 to July 1, 2013	0.5%	2.4%
Population, 2010	75,129	6,346,105
Persons under 5 years, percent, 2013	5.3%	6.2%
Persons under 18 years, percent, 2013	21.1%	23.0%
Persons 65 years and over, percent, 2013	18.5%	14.7%
Female persons, percent, 2013	51.5%	51.2%
White alone, percent, 2013 (a)	92.2%	79.1%
Black or African American alone, percent, 2013 (a)	4.2%	17.0%
American Indian and Alaska Native alone, percent, 2013 (a)	0.4%	0.4%
Asian alone, percent, 2013 (a)	1.2%	1.6%
Native Hawaiian and Other Pacific Islander alone, percent,	Z	0.1%
2013 (a) Two or More Races, percent, 2013	1.9%	1.7%
Hispanic or Latino, percent, 2013 (b)	2.4%	4.9%
White alone, not Hispanic or Latino, percent, 2013	90.1%	74.9%
Living in same house 1 year & over, percent, 2009-2013	85.9%	84.69
	3.0%	
Foreign born persons, percent, 2009-2013  Language other than English spoken at home, pct age 5+,	0.070	1.07
2009-2013	3.8%	6.6%
High school graduate or higher, percent of persons age 25+, 2009-2013	83.8%	84.4%
Bachelor's degree or higher, percent of persons age 25+, 2009-2013	23.5%	23.8%
Veterans, 2009-2013	7,105	484,90
Mean travel time to work (minutes), workers age 16+, 2009-2013	23.0	24.
Housing units, 2013	34,591	2,840,91
Homeownership rate, 2009-2013	68.5%	67.89
Housing units in multi-unit structures, percent, 2009-2013	15.7%	18.39
Median value of owner-occupied housing units, 2009-2013	\$127,000	\$139,20
Households, 2009-2013	30,548	
Persons per household, 2009-2013	2.43	2.5
Per capita money income in past 12 months (2013 dollars), 2009-2013	\$24,561	\$24,40
Median household income, 2009-2013	\$43,620	\$44,29
Persons below poverty level, percent, 2009-2013	18.2%	17.69
Business QuickFacts	Anderson County	Tennessee
Required darkii sale		130,819



State & County QuickFacts

## **Blount County, Tennessee**

People QuickFacts	Blount County	Tennessee
Population, 2014 estimate	126,339	6,549,352
Population, 2013 estimate	125,045	6,497,269
Population, 2010 (April 1) estimates base	123,016	6,346,275
Population, percent change - April 1, 2010 to July 1, 2014	2.7%	3.2%
Population, percent change - April 1, 2010 to July 1, 2013	1.6%	2.4%
Population, 2010	123,010	6,346,105
Persons under 5 years, percent, 2013	5.2%	6.2%
Persons under 18 years, percent, 2013	21.4%	23.0%
Persons 65 years and over, percent, 2013	17.9%	14.7%
Female persons, percent, 2013	51.5%	51.2%
White alone, percent, 2013 (a)	94.2%	79.1%
Black or African American alone, percent, 2013 (a)	2.9%	17.0%
American Indian and Alaska Native alone, percent, 2013 (a)	0.4%	0.4%
Asian alone, percent, 2013 (a)	0.9%	1.6%
Native Hawaiian and Other Pacific Islander alone, percent, 2013 (a)	Z	0.1%
Two or More Races, percent, 2013	1.5%	1.7%
Hispanic or Latino, percent, 2013 (b)	3.0%	4.9%
White alone, not Hispanic or Latino, percent, 2013	91.6%	74.9%
Living in same house 1 year & over, percent, 2009-2013	85.1%	84.6%
Foreign born persons, percent, 2009-2013	2.7%	4.6%
Language other than English spoken at home, pct age 5+, 2009-2013	3.9%	6.6%
High school graduate or higher, percent of persons age 25+, 2009-2013	86.7%	84.4%
Bachelor's degree or higher, percent of persons age 25+, 2009-2013	20.8%	23.8%
Veterans, 2009-2013	11,723	484,90
Mean travel time to work (minutes), workers age 16+, 2009- 2013	23.9	24.3
Housing units, 2013	55,427	2,840,914
Homeownership rate, 2009-2013	73.3%	67.89
Housing units in multi-unit structures, percent, 2009-2013	11.3%	18.39
Median value of owner-occupied housing units, 2009-2013	\$163,900	\$139,20
Households, 2009-2013	48,728	2,475,19
Persons per household, 2009-2013	2.50	2.5
Per capita money income in past 12 months (2013 dollars), 2009-2013	\$23,788	\$24,40
Median household income, 2009-2013	\$45,991	\$44,29
Persons below poverty level, percent, 2009-2013	13.7%	17.69
Business QuickFacts	Blount County	Tennessee
Private nonfarm establishments, 2013	2,263	



State & County QuickFacts

## **Hamblen County, Tennessee**

People QuickFacts	Hamblen County	Tennessee
Population, 2014 estimate	63,036	6,549,352
Population, 2013 estimate	63,078	6,497,269
Population, 2010 (April 1) estimates base	62,541	6,346,275
Population, percent change - April 1, 2010 to July 1, 2014	0.8%	3.2%
Population, percent change - April 1, 2010 to July 1, 2013	0.9%	2.4%
Population, 2010	62,544	6,346,105
Persons under 5 years, percent, 2013	6.3%	6.2%
Persons under 18 years, percent, 2013	23.5%	23.0%
Persons 65 years and over, percent, 2013	17.3%	14.7%
Female persons, percent, 2013	51.2%	51.2%
White alone, percent, 2013 (a)	91.8%	79.1%
Black or African American alone, percent, 2013 (a)	4.5%	17.0%
American Indian and Alaska Native alone, percent, 2013 (a)	0.8%	0.4%
Asian alone, percent, 2013 (a)	0.9%	1.6%
Native Hawaiian and Other Pacific Islander alone, percent, 2013 (a)	0.2%	0.1%
Two or More Races, percent, 2013	1.8%	1.7%
Hispanic or Latino, percent, 2013 (b)	11.0%	4.9%
White alone, not Hispanic or Latino, percent, 2013	82.4%	74.9%
Living in same house 1 year & over, percent, 2009-2013	86.9%	84.6%
Foreign born persons, percent, 2009-2013	7.0%	4.6%
Language other than English spoken at home, pct age 5+, 2009-2013	10.4%	6.6%
High school graduate or higher, percent of persons age 25+, 2009-2013	80.4%	84.4%
Bachelor's degree or higher, percent of persons age 25+, 2009-2013	16.0%	23.8%
Veterans, 2009-2013	5,244	484,901
Mean travel time to work (minutes), workers age 16+, 2009-2013	21.4	24.3
Housing units, 2013	26,931	2,840,914
Homeownership rate, 2009-2013	69.6%	67.8%
Housing units in multi-unit structures, percent, 2009-2013	15.7%	18.3%
Median value of owner-occupied housing units, 2009-2013	\$125,000	\$139,200
Households, 2009-2013	24,315	2,475,195
Persons per household, 2009-2013	2.55	2.52
Per capita money income in past 12 months (2013 dollars), 2009-2013	\$21,261	\$24,409
Median household income, 2009-2013	\$39,596	\$44,298
Persons below poverty level, percent, 2009-2013	19.2%	17.6%
Business QuickFacts	Hamblen County	Tennessee
Private nonfarm establishments, 2013	1,291	130,819 <sup>1</sup>



State & County QuickFacts

# **Jefferson County, Tennessee**

People QuickFacts	Jefferson County	Tennessee
Population, 2014 estimate	52,677	6,549,352
Population, 2013 estimate	52,296	6,497,269
Population, 2010 (April 1) estimates base	51,570	6,346,275
Population, percent change - April 1, 2010 to July 1, 2014	2.1%	3.2%
Population, percent change - April 1, 2010 to July 1, 2013	1.4%	2.4%
Population, 2010	51,407	6,346,105
Persons under 5 years, percent, 2013	5.3%	6.2%
Persons under 18 years, percent, 2013	21.1%	23.0%
Persons 65 years and over, percent, 2013	18.4%	14.7%
Female persons, percent, 2013	50.9%	51.2%
White alone, percent, 2013 (a)	95.5%	79.1%
Black or African American alone, percent, 2013 (a)	2.4%	17.0%
American Indian and Alaska Native alone, percent, 2013 (a)	0.4%	0.4%
Asian alone, percent, 2013 (a)	0.4%	1.6%
Native Hawaiian and Other Pacific Islander alone, percent, 2013 (a)	Z	0.1%
Two or More Races, percent, 2013	1.2%	1.7%
Hispanic or Latino, percent, 2013 (b)	3.5%	4.9%
White alone, not Hispanic or Latino, percent, 2013	92.4%	74.9%
Living in same house 1 year & over, percent, 2009-2013	85.6%	84.6%
Foreign born persons, percent, 2009-2013	1.8%	4.6%
Language other than English spoken at home, pct age 5+, 2009-2013	3.1%	6.6%
High school graduate or higher, percent of persons age 25+, 2009-2013	80.4%	84.4%
Bachelor's degree or higher, percent of persons age 25+, 2009-2013	13.6%	23.8%
Veterans, 2009-2013	4,980	484,90
Mean travel time to work (minutes), workers age 16+, 2009-2013	26.0	24.3
Housing units, 2013	23,437	2,840,914
Homeownership rate, 2009-2013	74.5%	67.8%
Housing units in multi-unit structures, percent, 2009-2013	8.7%	18.39
Median value of owner-occupied housing units, 2009-2013	\$121,800	\$139,20
Households, 2009-2013	19,797	2,475,19
Persons per household, 2009-2013	2.53	2.52
Per capita money income in past 12 months (2013 dollars), 2009-2013	\$20,619	\$24,40
Median household income, 2009-2013	\$39,745	\$44,29
Persons below poverty level, percent, 2009-2013	18.3%	17.69
Business QuickFacts	Jefferson County	Tennessee
		130,819



State & County QuickFacts

# **Knox County, Tennessee**

People QuickFacts	Knox County	Tennessee
Population, 2014 estimate	448,644	6,549,352
Population, 2013 estimate	444,350	6,497,269
Population, 2010 (April 1) estimates base	432,234	6,346,275
Population, percent change - April 1, 2010 to July 1, 2014	3.8%	3.2%
Population, percent change - April 1, 2010 to July 1, 2013	2.8%	2.4%
Population, 2010	432,226	6,346,105
Persons under 5 years, percent, 2013	5.9%	6.2%
Persons under 18 years, percent, 2013	21.5%	23.0%
Persons 65 years and over, percent, 2013	14.1%	14.7%
Female persons, percent, 2013	51.4%	51.2%
White alone, percent, 2013 (a)	86.4%	79.1%
Black or African American alone, percent, 2013 (a)	9.1%	17.0%
American Indian and Alaska Native alone, percent, 2013 (a)	0.4%	0.4%
Asian alone, percent, 2013 (a)	2.1%	1.6%
Native Hawaiian and Other Pacific Islander alone, percent, 2013 (a)	0.1%	0.1%
Two or More Races, percent, 2013	1.9%	1.7%
Hispanic or Latino, percent, 2013 (b)	3.7%	4.9%
White alone, not Hispanic or Latino, percent, 2013	83.3%	74.9%
Living in same house 1 year & over, percent, 2009-2013	86.8%	84.6%
Foreign born persons, percent, 2009-2013	4.7%	4.6%
Language other than English spoken at home, pct age 5+, 2009-2013	6.3%	6.6%
High school graduate or higher, percent of persons age 25+, 2009-2013	90.2%	84.4%
Bachelor's degree or higher, percent of persons age 25+, 2009-2013	34.3%	23.8%
Veterans, 2009-2013	28,744	484,90
Mean travel time to work (minutes), workers age 16+, 2009-2013	21.4	24.3
Housing units, 2013	197,288	2,840,91
Homeownership rate, 2009-2013	65.2%	
Housing units in multi-unit structures, percent, 2009-2013	23.1%	18.39
Median value of owner-occupied housing units, 2009-2013	\$157,400	\$139,20
Households, 2009-2013	181,100	2,475,19
Persons per household, 2009-2013	2.35	2.5
Per capita money income in past 12 months (2013 dollars), 2009-2013	\$28,136	\$24,40
Median household income, 2009-2013	\$47,694	
Persons below poverty level, percent, 2009-2013	14.6%	ion conserv
	Knox County	Tennessee
Business QuickFacts	County	,0,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,



State & County QuickFacts

## **Sevier County, Tennessee**

People QuickFacts	Sevier County	Tennessee
Population, 2014 estimate	95,110	6,549,352
Population, 2013 estimate	93,693	6,497,269
Population, 2010 (April 1) estimates base	89,876	6,346,275
Population, percent change - April 1, 2010 to July 1, 2014	5.8%	3.2%
Population, percent change - April 1, 2010 to July 1, 2013	4.2%	2.4%
Population, 2010	89,889	6,346,105
Persons under 5 years, percent, 2013	5.6%	6.2%
Persons under 18 years, percent, 2013	21.4%	23.0%
Persons 65 years and over, percent, 2013	17.1%	14.7%
Female persons, percent, 2013	50.9%	51.2%
White alone, percent, 2013 (a)	96.0%	79.1%
Black or African American alone, percent, 2013 (a)	1.2%	17.0%
American Indian and Alaska Native alone, percent, 2013 (a)	0.5%	0.4%
Asian alone, percent, 2013 (a)	1.1%	1.6%
Native Hawaiian and Other Pacific Islander alone, percent, 2013 (a)	Z	0.1%
Two or More Races, percent, 2013	1.2%	1.7%
Hispanic or Latino, percent, 2013 (b)	5.5%	4.9%
White alone, not Hispanic or Latino, percent, 2013	91.0%	74.9%
Living in same house 1 year & over, percent, 2009-2013	83.9%	84.6%
Foreign born persons, percent, 2009-2013	5.2%	4.6%
Language other than English spoken at home, pct age 5+, 2009-2013	6.8%	6.6%
High school graduate or higher, percent of persons age 25+, 2009-2013	82.3%	84.4%
Bachelor's degree or higher, percent of persons age 25+, 2009-2013	15.0%	23.8%
Veterans, 2009-2013	7,284	484,901
Mean travel time to work (minutes), workers age 16+, 2009-2013	25.5	24.3
Housing units, 2013	56,047	2,840,914
Homeownership rate, 2009-2013	66.8%	67.8%
Housing units in multi-unit structures, percent, 2009-2013	16.8%	18.39
Median value of owner-occupied housing units, 2009-2013	\$159,400	\$139,20
Households, 2009-2013	36,815	
Persons per household, 2009-2013	2.45	2.5
Per capita money income in past 12 months (2013 dollars), 2009-2013	\$22,242	\$24,40
Median household income, 2009-2013	\$43,649	\$44,29
Persons below poverty level, percent, 2009-2013	14.5%	17.6%
Business QuickFacts	Sevier County	Tennessee
Private nonfarm establishments, 2013	2,546	130,819

	5				



BERGEIN F. OVERHOLT, MD, MACP, MACG, FASGE BARRY V. MAVES, MD, FACG

SARKIS J. CHOBANIAN, MD,

CHARLES M. O'CONNOR, MD, FACG

J. DAVID LEE, MD, FACG

MEADE C. EDMUNDS, MD, FACG

JOHN M. HAYDEK, MD, FACP, FACG, AGAF, FASGE MARIA B. NEWMAN, MD.

DIPLOMAT ABIM
RAJ I. NARAYANI, MD,
FACG, FASGE

STEVEN J. BINDRIM, MD, DIPLOMAT ABIM

SCOTT L. WILHOITE, MD, JOHNNY ALTAWIL, MD, JAMES A SWENSON, MD,

R. LESLIE HARGROVE, MD, FACP (retired)

R. KENT FARRIS, MD, FACP, FACG (retired) F. RAYMOND PORTER, MD,

FACP (retired)
STANLEY L. MILLER, MD,
DIPLOMAT ABIM (retired)

JEFF DEW, CPA CEO

> MAIN OFFICE 301 WEISGARBER ROAD, #100 KNOXVILLE, TN 37909

P.O. BOX 59002 KNOXVILLE, TN 37950-9002 865.588.5121

FAX 865.588.2126 PLEASE VISIT US AT: www.gihealthcare.com

NORTH OFFICE 629 DELOZIER WAY

629 DELOZIER WAY P.O. BOX 59002 KNOXVILLE, TN 37950-9002

> 865,588,5121 FAX 865,588,2126

WEST OFFICE

11440 PARKSIDE DRIVE P.O. BOX 59002 KNOXVILLE, TN 37950-9002

865.588.5121 FAX 865.588.2126 June 30, 2015

Mr. Lonnie Matthews Tennessee Department of Health Health Statistics 2<sup>nd</sup> Floor, Andrew Johnson Tower 710 James Robertson Parkway Nashville, TN 37243

RE: 2013 Joint Annual Report Corrections for The Endoscopy Center (47285); The Knoxville Endoscopy Center – West (47745); The Endoscopy Center North (47736)

Dear Mr. Matthews:

In reviewing our Joint Annual Reports for the above referenced ambulatory surgical treatment centers for the period ended June 30, 2013 and June 30, 2104, I became aware that an error in the downloading of this information had caused some information found on schedules D and E of the Joint Annual Reports to be misstated for 2013. I have attached copies of revised schedule D and E and would like to ask that you please put these in the appropriate files for these Joint Annual Reports for 2013.

For 2014, the error was limited to case volume and I have included worksheet D for all three facilities to correct the case volumes.

If you have any questions, please either call me at (865) 558-0644 or email me at <a href="mailto:ifdew@gihealthcare.com">ifdew@gihealthcare.com</a>. Your assistance is greatly appreciated.

Sincerely,

Jeff Dew

Chief Executive Officer

# The Endoscopy Center 47285

State ID:	47285	Facility Name:		The Endoscop	y Center	
		Schedule D - A	vailability and Utili	zation of Services		
124111	in the Albert	Do not enter z	ero. Blank fields w	ill represent zero.		
	Please de	not use all UPI	PER case letters wh	en filling out the s	chedules.	
	Pleas	e provide the fo	llowing to cover the	e entire reporting p	eriod.	
ar was	Number of Opera	0				
Availability	Number of Proce	dure Rooms				8
of Rooms	Number of Birthi	ng Rooms				0
procedures f	k the "Yes/No" co for those services tient may receive	during the report	the services the facili- ing period. Number rvices listed.	ity offers and indicate of patients may inclu	e the number o	of patients and because
ino odinio po		single or multi sp			Single 9	Specialty
- 1113	to your lability a	Type of Se		Yes/No	Patients	Procedures
	Acupuncture	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	* 11/22-15	No		
	Dental			No		
	Ear, Nose, & Ti	roat (ENT)		No		
	Endoscopy			Yes	10462	14241
	General Surger	У		No		
	Gynecology	*		No		
	Hand Surgery			No		
	Infertility			No		
	Neurology			No		
	Obstetrics			No		
	Ophthalmology			No		
	Oral Surgery			No		
Utilization	Orthopedics			No		
of	Otolaryngology			No		
Services	Pain Managem	ent		No		
	Plastic Surgery			No		
	Podiatry			No		
	Pulmonary			No		
	Radiological/O	ncology Treatme	nt	No		
	Urology			No		
	Vascular			No		
	Other(1), spec	ify:		No		
	Other(2), spec			No		
	Other(3), spec	ify:		No		-
				Total:	10462	14241

State ID:	47285	Facility Nan				doscopy Cen	ter	
		Schedule D	- Availak	ility and Uti	lization of S	ervices		
		Do not ente	r zero. E	Blank fields	will represen	t zero.		
	Please	do not use all	JPPER ca	ase letters v	vhen filling o	ut the schedu	les.	
	Ple	ase provide the	followin	g to cover t	he entire rep	orting period.		Ale
"Case" shal	Il mean one vis	it to an Operatin erformed during	g Room of that visit.	r to a Proced	dure Room by	one patient, re	egardiess of	the number
		ormed in all Ope						0
Total number	r of cases perfe	ormed in all Proc	edure Ro	oms *			11	788
	r of cases for a						11	788
		of patients serve	ed **				10	462
		red to a hospital		sion				5
					onth			0
Average nun	nper of patients	in overnight obsumber of patients	Servation	setting per n				
(Schedule E		with Total Patie			r of Units	If Mobile**,		us Mobile
	Type of Equi		Yes/			number of		
	Type of Equip	oment on Site	No	Fixed	Mobile**	days per week	Patients	Procedure
		oment on Site		Fixed	Mobile**	days per	Patients	Procedure
	Computerize		No	Fixed	Mobile**	days per	Patients	Procedure
Availability	Computerize (CT/CAT)	d Tomography	No No No	Fixed	Mobile**	days per	Patients	Procedure
and	Computerize (CT/CAT) Ultrafast CT Linear Accele	d Tomography erator	No No	Fixed	Mobile**	days per	Patients	Procedure
and Utilization of	Computerize (CT/CAT) Ultrafast CT Linear Accele Lithotriptor Magnetic Re	d Tomography erator sonance	No No No	Fixed	Mobile**	days per	Patients	Procedure
and Utilization	Computerize (CT/CAT) Ultrafast CT Linear Accele	d Tomography erator sonance	No No No No	Fixed	Mobile**	days per	Patients	Procedure
and Utilization of	Computerize (CT/CAT) Ultrafast CT Linear Accele Lithotriptor Magnetic Re Imaging (MR	d Tomography erator sonance	No No No No No	Fixed	Mobile**	days per	Patients	Procedure
and Utilization of	Computerize (CT/CAT) Ultrafast CT Linear Accele Lithotriptor Magnetic Re Imaging (MR Upright MRI Mammograp Megavoltage	d Tomography erator sonance RI) bhy e Radiation	No No No No No No No	Fixed	Mobile**	days per	Patients	Procedure
and Utilization of	Computerize (CT/CAT) Ultrafast CT Linear Accele Lithotriptor Magnetic Re Imaging (MR Upright MRI Mammograp	d Tomography erator sonance RI) ohy e Radiation ission	No No No No No No No No No	Fixed	Mobile**	days per	Patients	Procedure
and Utilization of	Computerize (CT/CAT) Ultrafast CT Linear Accele Lithotriptor Magnetic Re Imaging (MR Upright MRI Mammograp Megavoltage Positron Em	d Tomography erator sonance RI) ohy e Radiation ission	No	Fixed	Mobile**	days per	Patients	Procedure

State ID:	47285	Facility Name:		The En	doscopy Cen	iter	
				haracteristics			
	D	o not enter zero.  B	lank fields wi	II represent zer	o patients.		
Number of	Δ σ ο	Ger	nder	Total patients		Race	
patients served	Age	Female	Male	served	White	Black	Other
during this	17 and under	1		1	1		
reporting period	18-64	3,684	2,698	6,382	6,046	275	61
by Age,	65-84	2,105	1,798	3,903	3,740	125	38
Gender and	85 and older	97	79	176	166	10	
Race	Total Patie	nts 5,887	4,575	10,462	9,953	410	99

State ID:	47285 Facilit	y Name:		The Endosco	py Center	
			- Patient Characte			
	Do not en	ter zero.  Blar	ık fields will repres	ent zero pati	ents.	
	Please enter the reperiod.	umber of patie	ents from each coun		ed services during to	
	County	Number of Patients	County	Number of Patients	County	Number of Patients
	01 Anderson	396	33 Hamilton	7	65 Morgan	24
	02 Bedford	1	34 Hancock	10	66 Obion	
	03 Benton		35 Hardeman		67 Overton	1
	04 Bledsoe		36 Hardin		68 Perry	
	05 Blount	349	37 Hawkins	22	69 Pickett	
	06 Bradley	10	38 Haywood		70 Polk	2
	07 Campbell	324	39 Henderson		71 Putnam	7
	08 Cannon		40 Henry		72 Rhea	5
	09 Carroll	1	41 Hickman		73 Roane	153
	10 Carter	1	42 Houston		74 Robertson	
	11 Cheatham		43 Humphreys		75 Rutherford	2
	12 Chester		44 Jackson		76 Scott	86
	13 Claiborne	164	45 Jefferson	438	77 Sequatchie	1
Patient Origin	14 Clay		46 Johnson		78 Sevier	620
, anone origin	15 Cocke	155	47 Knox	6,424	79 Shelby	
Tennessee	16 Coffee		48 Lake		80 Smith	
Counties	17 Crockett		49 Lauderdale		81 Stewart	
	18 Cumberland	27	50 Lawrence		82 Sullivan	4
	19 Davidson		51 Lewis		83 Sumner	1
	20 Decatur		52 Lincoln	2	84 Tipton	
	21 DeKalb		53 Loudon	224	85 Trousdale	
	22 Dickson		54 McMinn	51	86 Unicoi	3
	23 Dyer	1	55 McNairy		87 Union	211
	24 Fayette		56 Macon		88 Van Buren	
	25 Fentress	2	57 Madison		89 Warren	1
	26 Franklin		58 Marion		90 Washington	6
	27 Gibson	2	59 Marshall		91 Wayne	
	28 Giles		60 Maury		92 Weakley	
	29 Grainger	214	61 Meigs	6	93 White	1
	30 Greene	25	62 Monroe	81	94 Williamson	
	31 Grundy		63 Montgomery		95 Wilson	2
	32 Hamblen	215	64 Moore		96 Unknown	30
				Total Te	nnessee Patients	10,31

State ID:	47285	47285 Facility Name: The Endoscopy Center							
-				E - Patient Character					
155 C		Do not ente	er zero. Bl	ank fields will represe	ent zero pa	ntients.	والتعالب		
	01 Alab		8	18 Kentucky	48	34 North Carolina	11		
Patient Orig	in 04 Arka	ansas	2	25 Mississippi	5	47 Virginia	17		
Out of Stat	11 Coc		6	26 Missouri	2	55 Other States/ Countries	51		
		-		Total Patients from	Other Sta	tes and Countries	150		
			Tota	I Tennessee and Oth	er States/C	Countries Patients	10,46		

<sup>\*</sup> Total Tennessee and Other States/Countries Patients should match Total Unduplicated Patients from the Utilization of Services section (Schedule D) and from the Total Patients Served section (Schedule E)

# 2014 Joint Annual Report of Ambulatory Surgical Treatment Centers

State ID:	47285	Facility Name:		The Endoscopy Ce	nter	2014
		Schedule D - Ava	ilability and Utilizat	ion of Services		
	1000		omplete ALL fields.			
		not use all UPPER c				No. of the second
		Provide the followin	g to cover the entir	e reporting perio	d.	
	Number of Ope					0
Availability	Number of Pro	cedure Rooms			8	
of Rooms	Number of Birt	hing Rooms				0
procedures t	for those service tient may receiv	for each of the services during the reporting e several of the service	period. Number of ces listed.	and indicate the nupatients may inclu	de duplicates	because
	Is your facility	a single or multi spec	cialty facility?			Specialty
	Тур	e of Service - Compl	ete ALL fields	Yes/No	Patients	Procedures
	Acupuncture			No		
	Dental			No		
	Ear, Nose, &	Throat (ENT)		No		ļ
	Endoscopy		Yes	8402	11731	
	General Surg	ery	No			
	Gynecology		No			
	Hand Surgery			No		
	Infertility			No		
	Neurology			No		1
	Obstetrics			No		ļ
	Ophthalmolog	ЗУ		No		1
	Oral Surgery			No		
Utilization	Orthopedics			No		
of	Otolaryngolog	у		No		
Services	Pain Manage	ment		No		
	Plastic Surge	ry		No		
	Podiatry			No		
	Pulmonary			No		
	Radiological/	Oncology Treatment		No		
	Urology			No		
	Vascular			No		
	Other(1), spe	cify:		No		
	Other(2), spe	cify:		No		
	Other(3), spe	cify:		No		
				Total:	8402	11731

# 2014 Joint Annual Report of Ambulatory Surgical Treatment Centers

State ID:	47285	Facility Nan	ne:		The Endo	scopy Center		2014
		Schedule D	- Availal	oility and Ut	ilization of So	ervices		
	F - 1 - 1 - 1		Com	plete ALL fie	elds.			
	Do	not use all UPF	PER case	letters whe	n filling out t	he schedules.		
		Provide the fol	llowing to	cover the	entire reporti	ng period.		
* "Case" sha	II mean one visi	it to an Operatin	g Room o	or to a Procee	dure Room by	one patient, re	egardless of	the number
		erformed during						0
Total numbe	r of cases perfo	ormed in all Ope	rating Ro	oms *				953
Total numbe	r of cases perfo	ormed in all Proc	edure Ro	oms ^				
Total numbe	r of cases for al	ll rooms *					99	953 
**Total undu	plicated number	r of patients ser	ved				84	102
		red to a hospital	107 1 1 1 1 1 1 1 1 1 1	ssion				6
								0
Average nur	nber of patients	in overnight obs	servation	setting per n	nonth			
	)			-				
<u>Residents</u> (Schedule E	)		Voci	Numbe	r of Units	If Mobile***,	Fixed pl	us Mobile
	) Type of Equip	oment on Site	Yes/ No	Numbe Fixed	r of Units  Mobile***	If Mobile***, number of days per week	Fixed pl	
	Type of Equip	oment on Site		1		number of days per		us Mobile Procedure
Schedule E	Type of Equip		No	1		number of days per		
Schedule E	Type of Equip	d Tomography	No No	1		number of days per		
Availability and	Type of Equip  Computerized (CT/CAT)  Ultrafast CT  Linear Accele	d Tomography erator	No No	1		number of days per		
Availability and Utilization of	Computerized (CT/CAT) Ultrafast CT Linear Accele	d Tomography erator sonance	No No No	1		number of days per		
Availability and Utilization	Computerized (CT/CAT) Ultrafast CT Linear Accelet Lithotriptor Magnetic Res	d Tomography erator sonance	No No No No	1		number of days per		
Availability and Utilization of	Computerized (CT/CAT) Ultrafast CT Linear Accelet Lithotriptor Magnetic Resulting (MR	d Tomography erator sonance	No No No No	1		number of days per		
Availability and Utilization of	Computerized (CT/CAT) Ultrafast CT Linear Acceler Lithotriptor Magnetic Resident (MR) Upright MRI Mammograp Megavoltage	d Tomography erator sonance	No No No No No No No	1		number of days per		
Availability and Utilization of	Type of Equip  Computerized (CT/CAT)  Ultrafast CT  Linear Accele Lithotriptor  Magnetic Res Imaging (MR)  Upright MRI  Mammograp	erator sonance	No No No No No No No No	1		number of days per		
Availability and Utilization of	Type of Equip  Computerized (CT/CAT)  Ultrafast CT  Linear Accele  Lithotriptor  Magnetic Res Imaging (MR)  Upright MRI  Mammograp  Megavoltage  Positron Emi	erator sonance	No	1		number of days per		

# The Knoxville Endoscopy Center - West 47745

State ID:	47745	Facility Name:	The K	noxville Endosco	py Center-We	est	
		Schedule D - Av	ailability and Utiliza	tion of Services			
	20 5 TO NO.		ro. Blank fields will				
	Please do	not use all UPPI	ER case letters whe	n filling out the s	chedules.		
	Pleas	e provide the foll	owing to cover the	entire reporting p	eriod.		
7	Number of Opera			<del></del>	0		
Availability	Number of Proce				2		
of Rooms	Number of Birthir	ig Rooms				0	
Please chec	k the "Yes/No" col	umn for each of th	e services the facility	offers and indicate	e the number o	of patients and	
procedures f	or those services	during the reporting	g period. Number of	patients may inclu	de duplicates	because	
he same pa	tient may receive	several of the serv	ices listed.				
	Is your facility a	single or multi spe	cialty facility?			Specialty	
		Type of Ser	vice	Yes/No	Patients	Procedures	
	Acupuncture			No			
	Dental			No			
	Ear, Nose, & Th	roat (ENT)		No			
	Endoscopy			Yes	3420	4572	
	General Surger	/	No				
	Gynecology			No			
	Hand Surgery		No				
	Infertility		No				
	Neurology			No			
	Obstetrics			No			
	Ophthalmology			No			
	Oral Surgery			No			
Utilization	Orthopedics			No			
of	Otolaryngology			No			
Services	Pain Manageme	ent		No			
	Plastic Surgery			No			
	Podiatry			No			
	Pulmonary			No			
	Radiological/Or	icology Treatment		No			
	Urology			No			
	Vascular			No			
	Other(1), specif			No			
	Other(2), speci			No			
	Other(3), speci	fy:		No		_	
				Total:	3420	4572	
				i Otali	3 120	,,,,,	

State ID:		Facility Name: The Knoxville Endoscopy Center-West						
	Schedu	le D - Availa	bility and Ut	ilization of S	ervices			
	Do not	enter zero.	Blank fields	will represen	it zero.			
	Please do not use	all UPPER c	ase letters v	vhen filling o	ut the schedu	iles.		
	Please provide	the following	ng to cover	the entire rep	orting period		11 1	
* "Case" shal of surgeries o	I mean one visit to an Oper r procedures performed du	rating Room or Iring that visit	or to a Proced	dure Room by	one patient, re	egardless of	tne number	
Total number of cases performed in all Operating Rooms *							0	
Total number of cases performed in all Procedure Rooms *							3749	
Total number of cases for all rooms *							3749	
Total unduplicated number of patients served **							120	
Number of patients transferred to a hospital for admission							2	
	nber of patients in overnigh			nonth			0	
	induplicated number of pat				number of pat	ients and pro	ocedures	
reported, bu (Schedule E	t should agree with Total P	atients Serve	d and Total	Tennessee an	d Non-Tennes	see Resider	nts 	
			Number of Units		If Mobile**,	Fixed plus Mobile		
	Type of Equipment on Si	te Yes/ No	Fixed	Mobile**	number of days per week	Patients	Procedure	
	Computerized Tomograp	hy No						
	(CT/CAT)	No						
	(CT/CAT) Ultrafast CT	No						
Availability		· NO						
and	Ultrafast CT Linear Accelerator Lithotriptor	No						
and Utilization of	Ultrafast CT Linear Accelerator	No No						
and Utilization	Ultrafast CT Linear Accelerator Lithotriptor Magnetic Resonance	No No No						
and Utilization of	Ultrafast CT Linear Accelerator Lithotriptor Magnetic Resonance Imaging (MRI)	No No No No				10.51		
and Utilization of	Ultrafast CT Linear Accelerator Lithotriptor Magnetic Resonance Imaging (MRI) Upright MRI	No No No No						
and Utilization of	Ultrafast CT Linear Accelerator Lithotriptor Magnetic Resonance Imaging (MRI) Upright MRI Mammography	No No No No No				40-71		
and Utilization of	Ultrafast CT Linear Accelerator Lithotriptor Magnetic Resonance Imaging (MRI) Upright MRI Mammography Megavoltage Radiation Positron Emission	No						

State ID:	47745	Facility Name:		The Knoxville Endoscopy Center-West					
				haracteristics					
	Do	not enter zero. Bl	ank fields wi	ll represent zero	patients.				
Number of patients served during this reporting period by Age, Gender and Race	Age	Gend	Gender		Race				
		Female	Male	patients - served	White	Black	Other		
	17 and under	1	1	2	1		1		
	18-64	1,261	904	2,165	2,077	57	31		
	65-84	625	569	1,194	1,155	16	23		
	85 and older	28	31	59	58		13		
	Total Patient	s 1,915	1,505	3,420	3,291	73	68		

	Sionai		VISIOII		IOVISIC		
State ID:	7745 Facility Name: The Knoxville Endoscopy Center-West						
			- Patient Characte	CONTRACTOR CONTRACTOR	onte	, 150MT S	
	Do not et	iter zero. Bian	ik fields will represents from each cour	ity who receive	ents. ed services during th	ne reporting	
	period.	number of pade	sitts from each ood	ity who receive		<b>3</b>	
	County	Number of Patients	County	Number of Patients	County	Number of Patients	
	01 Anderson	157	33 Hamilton	1	65 Morgan	35	
	02 Bedford		34 Hancock	1	66 Obion		
	03 Benton		35 Hardeman		67 Overton	1	
	04 Bledsoe	2	36 Hardin		68 Perry		
	05 Blount	175	37 Hawkins	3	69 Pickett		
	06 Bradley	3	38 Haywood		70 Polk		
	07 Campbell	25	39 Henderson		71 Putnam	4	
	08 Cannon		40 Henry		72 Rhea	18	
	09 Carroll		41 Hickman		73 Roane	212	
	10 Carter		42 Houston		74 Robertson		
	11 Cheatham		43 Humphreys		75 Rutherford	1	
	12 Chester		44 Jackson		76 Scott	21	
	13 Claiborne	19	45 Jefferson	44	77 Sequatchie		
Patient Origin	14 Clay		46 Johnson		78 Sevier	58	
	15 Cocke	23	47 Knox	1,660	79 Shelby		
Tennessee Counties	16 Coffee		48 Lake		80 Smith		
Counties	17 Crockett		49 Lauderdale		81 Stewart		
	18 Cumberland	67	50 Lawrence		82 Sullivan	111	
	19 Davidson	1	51 Lewis		83 Sumner	1	
	20 Decatur		52 Lincoln	4	84 Tipton		
	21 DeKalb		53 Loudon	462	85 Trousdale		
	22 Dickson		54 McMinn	94	86 Unicoi		
	23 Dyer		55 McNairy		87 Union	15	
	24 Fayette		56 Macon		88 Van Buren		
	25 Fentress	13	57 Madison		89 Warren		
	26 Franklin		58 Marion		90 Washington	1	
	27 Gibson		59 Marshall		91 Wayne		
	28 Giles		60 Maury		92 Weakley		
	29 Grainger	18	61 Meigs	17	93 White		
	30 Greene	3	62 Monroe	103	94 Williamson		
	31 Grundy		63 Montgomery		95 Wilson		
	32 Hamblen	26	64 Moore		96 Unknown	90	
				Total Te	nnessee Patients	3,379	

State ID:	47745	Facility	Name:	The Kno	xville Endo	oscopy Center-West	
				E - Patient Character			
A-1 - 1 - 1		Do not ente	r zero. Bl	ank fields will represe	ent zero pa	tients.	
	01 Alab		2	18 Kentucky	12	34 North Carolina	
Patient Orig	in 04 Arka	nsas		25 Mississippi		47 Virginia	5
Out of Stat	11 000		5	26 Missouri		55 Other States/ Countries	17
				Total Patients from	Other Sta	tes and Countries	41
			Tota	I Tennessee and Oth			3,420

<sup>\*</sup> Total Tennessee and Other States/Countries Patients should match Total Unduplicated Patients from the Utilization of Services section (Schedule D) and from the Total Patients Served section (Schedule E)

## 2014 Joint Annual Report of Ambulatory Surgical Treatment Centers

State ID:	47745	Facility Name:	The Knox	ville Endoscopy (	Center-West	2014
Ottato III			lability and Utilizati	on of Services		
-7			mplete ALL fields.			A X A
	Do not	use all UPPER cas	se letters when filli	ng out the sched	dules.	
	Pro	vide the following	to cover the entire	reporting perio	d.	
-	Number of Operat					0
Availability	Number of Proces					2
of Rooms	Number of Birthin					0
Ohaali iha (V	( (NI all androws And	each of the convice	s the facility offers ar	nd indicate the nu	ımber of patier	nts and
procedures f	or those services of	Juring the reporting	period. Number of p	atients may inclu	de duplicates l	pecause
the same pa	tient may receive s	everal of the service	es listed.			
		single or multi specia			Single	Specialty
	Type o	of Service - Comple	te ALL fields	Yes/No	Patients	Procedures
	Acupuncture			No		
	Dental			No		
	Ear, Nose, & Thi	roat (ENT)		No		
	Endoscopy			Yes	4193	5893
	General Surgery			No		
	Gynecology			No		
	Hand Surgery			No		
	Infertility			No		
	Neurology			No		
	Obstetrics			No		
	Ophthalmology			No		
	Oral Surgery			No		
Utilization	Orthopedics			No		
of	Otolaryngology			No		
Services	Pain Manageme	ent		No		
	Plastic Surgery			No		
	Podiatry			No		-
	Pulmonary			No		
	Radiological/On	cology Treatment		No		
	Urology			No		_
	Vascular			No		-
	Other(1), specif	y:		No		-
	Other(2), specif			No		
	Other(3), specif	y:		No		
				1		N.
				Total:	4193	5893

#### 2014 Joint Annual Report of Ambulatory Surgical Treatment Centers

State ID:	47745	Facility Nan	ne:	The	Knoxville End	loscopy Center	-West	2014
		Schedule D	- Availal	oility and Ut	ilization of Se	rvices		
		MAN VERS		plete ALL fi				
		not use all UPF						
		Provide the fol	lowing to	o cover the	entire reporti	ng period.		0 1
* "Case" sha	Il mean one visi	t to an Operatin	g Room c	or to a Proce	dure Room by	one patient, re	egardless of	the number
	or procedures pe							0
Total numbe	r of cases perfo	rmed in all Ope	rating Ro	oms *				929
	r of cases perfo		edule Ro	101115				929
Total numbe	r of cases for al	I rooms *						
**Total undu	plicated number	of patients ser	ved				41	193
Number of p	atients transferr	ed to a hospital	for admis	ssion				2
					onth			0
Average nun	nber of patients unduplicated r	in overnight ob	Servation	Setting per n	41 15 -	T-tal warehow		
ochedule E	)							
Schedule E	)			Numbe	r of Units	If Mobile***,	Fixed pl	us Mobile
Scriedule E	Type of Equip	ment on Site	Yes/ No	Numbe Fixed	r of Units  Mobile***	If Mobile***, number of days per week	Fixed pl	
ochedule E	Type of Equip					number of days per		us Mobile Procedure
ochedule E	Type of Equip	ment on Site				number of days per		
ochedule E	Type of Equip		No			number of days per		
Availability	Type of Equip	d Tomography	No No			number of days per		
Availability and	Type of Equip  Computerized (CT/CAT)  Ultrafast CT  Linear Accele	d Tomography erator	No No			number of days per		
Availability and Utilization of	Computerized (CT/CAT) Ultrafast CT Linear Accele	d Tomography erator sonance	No No No			number of days per		
Availability and Utilization	Type of Equip  Computerized (CT/CAT)  Ultrafast CT  Linear Accele  Lithotriptor  Magnetic Res	d Tomography erator sonance	No No No No			number of days per		
Availability and Utilization of	Computerized (CT/CAT) Ultrafast CT Linear Accele Lithotriptor Magnetic Res Imaging (MRI	d Tomography erator sonance	No No No No No			number of days per		
Availability and Utilization of	Type of Equip  Computerized (CT/CAT)  Ultrafast CT  Linear Acceler Lithotriptor  Magnetic Resimaging (MRI)  Upright MRI  Mammograph  Megavoltage	erator  sonance  l)  Radiation	No No No No No			number of days per		
Availability and Utilization of	Type of Equip  Computerized (CT/CAT)  Ultrafast CT  Linear Acceler Lithotriptor  Magnetic Result Imaging (MRI)  Upright MRI  Mammograph	erator  sonance  l)  Radiation ssion	No No No No No No No No No			number of days per		
Availability and Utilization of	Type of Equip  Computerized (CT/CAT)  Ultrafast CT  Linear Accelet Lithotriptor  Magnetic Res Imaging (MRI)  Upright MRI  Mammograph  Megavoltage  Positron Emis	erator  sonance  l)  Radiation ssion	No			number of days per		

# The Endoscopy Center North 47736

State ID:	47736	Facility Name:		The Endoscopy C	enter North	
			vailability and Utiliz			
	100	Do not enter ze	ro. Blank fields wi	II represent zero.		
	Please	do not use all UPP	ER case letters wh	en filling out the s	chedules.	
	Ple	ase provide the fol	lowing to cover the	entire reporting p	eriod.	
r versener	Number of Ope	erating Rooms				0
Availability	Number of Pro	cedure Rooms				2
of Rooms	Number of Birt	hing Rooms				0
procedures t	or those service	column for each of the es during the reporting e several of the sen	ne services the facilit ng period. Number o vices listed.	ty offers and indicate of patients may inclu	ide duplicates	because
	Is your facility	a single or multi spe	ecialty facility?			Specialty
		Type of Ser		Yes/No	Patients	Procedures
	Acupuncture			No		
	Dental			No		
	Ear, Nose, &	Throat (ENT)		No		
	Endoscopy			Yes	4384	5777
	General Surg	ery		No		
	Gynecology			No		
	Hand Surger	/		No		-
	Infertility			No		
	Neurology			No		-
	Obstetrics			No		
	Ophthalmolo	ЭУ		No		
	Oral Surgery			No		
Utilization	Orthopedics			No		
of	Otolaryngolo	ду		No		
Services	Pain Manage	ment		No		
	Plastic Surge	ery		No		
	Podiatry			No		
	Pulmonary			No		
		Oncology Treatmen	t	No		
	Urology			No		
	Vascular			No		
	Other(1), spe			No		+
	Other(2), spe			No		
	Other(3), spe	ecify:		No		
				Total:	4384	5777

State ID:	47736	Facility Nam				scopy Center	North	
		Schedule D	- Availab	ility and Ut	lization of S	ervices		
	Please (	do not use all l	JPPER ca	ise letters v	will represen vhen filling o	ut the schedu	iles.	
	Plea	se provide the	followin	g to cover t	he entire rep	orting period.		
* "Case" shall	l mean one visit r procedures pe	to an Operating	g Room o	r to a Proced	dure Room by	one patient, <u>re</u>	egardless of	the number
	of cases perfo			ms *				0
Total number	of cases perfo	rmed in all Proc	edure Ro	oms *			48	316
	of cases for all						48	316
Total undupli	cated number o	f patients serve	d **	12			43	384
	atients transferr			sion				1
	nber of patients				nonth			0
(Schedule E	.)			Numbe	r of Units	If Mobile**,	Fixed pl	us Mobile
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	Transact Florida	mant on Cita	100/			number of		
	Type of Equip	ment on Site	No	Fixed	Mobile**	days per week	Patients	Procedure
		ment on Site	NI CONTRACTOR	Fixed	Mobile**	days per	Patients	Procedure
	Computerized		No	Fixed	Mobile**	days per	Patients	Procedure
Availability	Computerized	l Tomography	No No	Fixed	Mobile**	days per	Patients	Procedure
and	Computerized (CT/CAT) Ultrafast CT	l Tomography	No No	Fixed	Mobile**	days per	Patients	Procedure
and Utilization of	Computerized (CT/CAT) Ultrafast CT Linear Accele Lithotriptor Magnetic Res	Tomography rator	No No No	Fixed	Mobile**	days per	Patients	Procedure
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State ID:	47736	Faci	lity Name:		The Endos	copy Center	North	
					haracteristics			
	D	o not e	nter zero. Bl	ank fields wi	l represent zero	patients.		
Number of			Gend	der	Total patients		Race	
patients served	Age		Female	Male	served	White	Black	Other
during this	17 and under				0			
reporting period	18-64		1,242	1,027	2,269	2,223	30	16
by Age,	65-84		1,068	964	2,032	2,011	13	8
Gender and	85 and older		37	46	83	82		1
Race	Total Patie	ents	2,347	2,037	4,384	4,316	43	25

The Endoscopy Center North **Facility Name:** State ID: 47736 Schedule E - Patient Characteristics Do not enter zero. Blank fields will represent zero patients. Please enter the number of patients from each county who received services during the reporting period. Number of Number of Number of County County County Patients Patients Patients 3 65 Morgan 33 Hamilton 01 Anderson 320 66 Obion 3 34 Hancock 02 Bedford 1 35 Hardeman 67 Overton 03 Benton 68 Perry 36 Hardin 04 Bledsoe 5 37 Hawkins 69 Pickett 25 05 Blount 70 Polk 38 Haywood 1 06 Bradley 71 Putnam 39 Henderson 435 07 Campbell 72 Rhea 40 Henry 08 Cannon 12 73 Roane 41 Hickman 09 Carroll 74 Robertson 42 Houston 10 Carter 75 Rutherford 43 Humphreys 11 Cheatham 86 76 Scott 44 Jackson 12 Chester 77 Sequatchie 1 53 45 Jefferson 218 13 Claiborne 40 78 Sevier 46 Johnson 14 Clay Patient Origin 79 Shelby 2.584 47 Knox 15 Cocke 15 80 Smith Tennessee 48 Lake 16 Coffee Counties 81 Stewart 1 49 Lauderdale 17 Crockett 1 82 Sullivan 50 Lawrence 4 18 Cumberland 83 Sumner 51 Lewis 19 Davidson 84 Tipton 52 Lincoln 20 Decatur 85 Trousdale 53 Loudon 21 DeKalb 4 86 Unicoi 54 McMinn 22 Dickson 338 87 Union 55 McNairy 23 Dyer 88 Van Buren 56 Macon 24 Fayette 89 Warren 57 Madison 25 Fentress 90 Washington 58 Marion 26 Franklin 91 Wayne 59 Marshall 27 Gibson 92 Weakley 60 Maury 28 Giles 93 White 61 Meigs 29 Grainger 98 94 Williamson 4 3 62 Monroe 30 Greene 95 Wilson 63 Montgomery 31 Grundy 12 96 Unknown 64 Moore 18 32 Hamblen **Total Tennessee Patients** 4.305

State ID:		17736	Facility	Name:	The	Endoscop	y Center North	
				Schedule	E - Patient Character	istics		
			o not ent	er zero. Bl	ank fields will repres	ent zero pa	itients.	
	-	01 Alab			18 Kentucky	53	34 North Carolina	1
5	e Tra	04 Arka	2200		25 Mississippi		47 Virginia	18
Patient Ori		11 Geo		1	26 Missouri		55 Other States/ Countries	6
					Total Patients from	Other Sta	tes and Countries	79
	-			Tota	al Tennessee and Oth			4,384

<sup>\*</sup> Total Tennessee and Other States/Countries Patients should match Total Unduplicated Patients from the Utilization of Services section (Schedule D) and from the Total Patients Served section (Schedule E)

## 2014 Joint Annual Report of Ambulatory Surgical Treatment Centers

State ID:	47736	Facility Name:	The	Endoscopy Cente	r North	2014
		Schedule D - Avai	lability and Utilizat	ion of Services		
VENT US		Co	omplete ALL fields.			
	Do no	t use all UPPER ca	se letters when filli	ng out the sched	dules.	
	P	ovide the following	to cover the entire	e reporting perio	d.	
	Number of Opera					0
Availability	Number of Proce					2
of Rooms	Number of Birthi	ng Rooms				0
procedures f	or those services	r each of the service during the reporting several of the servic	es the facility offers a period. Number of p es listed.	nd indicate the nu patients may inclu	de duplicates i	Jecause
		single or multi speci				Specialty
	Type	of Service - Comple	te ALL fields	Yes/No	Patients	Procedures
	Acupuncture			No		
	Dental			No		
	Ear, Nose, & Th	roat (ENT)		No		
	Endoscopy			Yes	5353	7817
	General Surger	ý		No		
	Gynecology			No		
	Hand Surgery			No		
	Infertility			No		
	Neurology			No		
	Obstetrics			No		
	Ophthalmology			No		
	Oral Surgery			No		
Utilization	Orthopedics			No		
of	Otolaryngology			No		
Services	Pain Managem	ent		No		
	Plastic Surgery			No		
	Podiatry			No		
	Pulmonary			No		
		ncology Treatment		No		
	Urology			No		
	Vascular			No		
	Other(1), spec	ify:		No		
	Other(2), spec			No		-
	Other(3), spec			No		
				Total:	5353	7817

#### 2014 Joint Annual Report of Ambulatory Surgical Treatment Centers

	47736	Facility Nar	ne:		The Endosco	py Center Nort	:h	2014
		Schedule D	- Availa	bility and Ut	ilization of S	ervices		
	siting is 1957		Com	plete ALL fi	elds.			
		ot use all UPF						
		rovide the fo						
* "Case" shall	Il mean one visit	to an Operatin	g Room o	or to a Proce	dure Room by	one patient, re	egardless of	the number
	r procedures per							0
	r of cases perfor							237
	r of cases perfor		equie Ro	ooms				
Total number	r of cases for all	rooms *					62	237
**Total undu	plicated number	of patients ser	ved				53	353
Number of p	atients transferre	ed to a hospital	for admis	ssion				1
	nber of patients in				nonth			0
	unduplicated n					T-4-1 1	af ma4!au4=	
Collecture L.	)							
(Schedule E				Numbe	r of Units	If Mobile***,	Fixed pl	us Mobile
Confedure L	Type of Equipn	nent on Site	Yes/ No	Numbe	r of Units  Mobile***	number of days per	Fixed pl	us Mobile Procedure
Contradic L	Type of Equipn					number of		T
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Availability	Type of Equipn Computerized (CT/CAT)	Tomography	No No			number of days per		T
Availability and	Type of Equipm Computerized (CT/CAT) Ultrafast CT	Tomography	No No			number of days per		T
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Availability and Utilization of	Type of Equipmed Computerized (CT/CAT) Ultrafast CT Linear Acceleration Lithotriptor Magnetic Resolating (MRI) Upright MRI Mammography	Tomography ator onance / Radiation	No No No No No No No No No			number of days per		T
Availability and Utilization of	Type of Equipmed Computerized (CT/CAT) Ultrafast CT Linear Acceleration Lithotriptor Magnetic Resolution (MRI) Upright MRI Mammography Megavoltage F Positron Emiss	Tomography ator onance / Radiation	No			number of days per		T

#### SUPPORT LETTERS



# State of Tennessee Health Services and Development Agency

Andrew Jackson, 9<sup>th</sup> Floor, 502 Deaderick Street, Nashville, TN 37243 **www.tn.gov/hsda** Phone: 615-741-2364 Fax: 615-741-9884

#### CONSENT CALENDAR

September 1, 2015

John Wellborn Dvelopment Support Group 4219 Hillsboro Road, Suite 210 Nashville, TN 37215

RE: Certificate of Need Application -- The Endoscopy Center of Knoxville - CN1508-030 To relocate The Endoscopy Center of Knoxville, an existing single specialty ASTC limited to endoscopy, from 801 Weisgarber Road, Suite 100, Knoxville to an unaddressed site in the northwest quadrant of the intersection of Middlebrook Pike and Dowell Springs Boulevard in Knoxville, Tennessee, a distance of approximately 1.4 miles. As a part of the project, the applicant will reduce its existing surgical complement from 8 to 6 procedure rooms. The estimated project cost is \$13,791,719.

#### Dear Mr. Wellborn:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need. Please be advised that your application is now considered to be complete by this office.

Your application is being forwarded to Trent Sansing at the Tennessee Department of Health for Certificate of Need review by the Division of Policy, Planning and Assessment. You may be contacted by Mr. Sansing or someone from his office for additional clarification while the application is under review by the Department. Mr. Sansing's contact information is Trent.Sansing@tn.gov or 615-253-4702.

In accordance with Tennessee Code Annotated, §68-11-1601, et seq., as amended by Public Chapter 780, the 30-day review cycle for **CONSENT CALENDAR** for this project will begin on September 1, 2015. The first thirty (30) days of the cycle are assigned to the Department of Health, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the thirty (30)-day period, a written report from the Department of Health or its representative will be forwarded to this office for Agency review within the thirty (30)-day period immediately following. You will receive a copy of their findings. The Health Services and Development Agency will review your application on October 28, 2015.

Mr. Wellborn September 1, 2015 Page 2

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

- (2) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.
- (3) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,

Melanie M. Hill Executive Director

Who lane M. Hell

cc: Trent Sansing, TDH/Health Statistics, PPA



#### **State of Tennessee Health Services and Development Agency**

Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243 www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

#### MEMORANDUM

TO:

Trent Sansing, CON Director

Office of Policy, Planning and Assessment

Division of Health Statistics

Andrew Johnson Tower, 2nd Floor 710 James Robertson Parkway Nashville, Tennessee 37243

FROM:

Melanie M. Hill **Executive Director** 

DATE:

September 1, 2015

RE:

Certificate of Need Application

The Endoscopy Center of Knoxville - CN1508-030

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a sixty (60) day review period to begin on September 1, 2015 and end on November 1, 2015.

Should there be any questions regarding this application or the review cycle, please contact this office.

Enclosure

cc:

John Wellborn

#### LETTER OF INTENT -- HEALTH SERVICES & DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Knoxville News Sentinel, which is a newspaper of general circulation in Knox County, Tennessee, on or before August 9, 2015, for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that The Endoscopy Center (an ambulatory surgical treatment center), owned by The Endoscopy Center of Knoxville, L.P. (a limited partnership), and managed by AmSurg Corp (a corporation), intends to file an application for a Certificate of Need to relocate from 801 Weisgarber Road, Suite 100, Knoxville, TN 37950 to an unaddressed site in the northwest quadrant of the intersection of Middlebrook Pike (TN 169) and Dowell Springs Boulevard in Knoxville, a distance of approximately 1.4 miles, and to reduce its procedure room complement from eight (8) to six (6) rooms. The project cost for CON purposes is estimated at \$14,000,000, of which approximately \$6,500,000 will be the actual capital cost. The balance consists of long-term lease payments that must be included under CON rules.

This facility is currently licensed by the Board for Licensing Health Care Facilities as a single specialty ambulatory surgical treatment center limited to endoscopy. The relocation will not change the facility's license classification. The project does not contain major medical equipment or initiate or discontinue any other health service; and it will not affect any facility's licensed bed complements.

The anticipated date of filing the application is on or before August 14, 2015. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 210, Nashville, TN 37215; (615) 665-2022.

(Signature) (Date) jwdsg@comcast.net (E-mail Address)

#### **SUPPLEMENTAL #1**

August 25, 2015 1:12 pm

# DSG Development Support Group

August 21, 2015

Jeff Grimm, HSD Examiner Tennessee Health Services and Development Agency Andrew Jackson Building, 9<sup>th</sup> Floor 502 Deaderick Street Nashville, TN 37243

RE: CON Application #1508-030s Endoscopy Center of Knoxville

Dear Mr. Grimm:

This letter responds to your recent request for additional information on this application. The items below are numbered to correspond to your questions. They are provided in triplicate, with affidavit.

1. Section A, Applicant Profile, Item 6

The 15-year option to sublease 16,732 rentable square feet in a new 50,000 SF 3-story building to be constructed on a 4.5 acre site at the intersection of Middlebrook Pike and Dowell Springs Boulevard in Knoxville, TN is noted.

a. Please provide proof of ownership of the 4.5-acre site by the owner identified in the document in the form of a copy of a title or deed.

RTG Dowell Springs, LLC is listed in the lease option as an owner. It holds four deeds to tracts comprising this project's site. Those deeds are attached at the end of this letter. The other owner listed in the option is DDC Dowell Springs, LLC. Its role is explained in a letter attached to the deeds. Both RTG and DDC signed the lease option, as did the intended master tenant (GIA, the practice) and its subtenant (the ASTC applying for the CON), assuring the CON applicant of site control.

b. Exhibit A reflects that the applicant will sublease 16,732 SF on the entire 2<sup>nd</sup> floor of the building. This amount appears to be different from the 17,173 SF used to calculate the lease cost for the Project Costs Chart on page 47 of the application. Please clarify.

Please see Exhibit A, item 2 in the lease option, which states 17,173 "rentable SF". That is the figure used in calculating lease costs. The smaller figure is the usable SF that exist within the applicant's premises. Their difference is the inclusion of a common area (halls, elevator, parking, etc.) factor when grossing up usable SF into rentable SF.

Page Two August 21, 2015

c. The terms also indicate that Gastrointestinal Associates, PC, as master tenant, will lease the entire building from the owner for use as medical office space and an ambulatory surgery center. Please briefly describe the plans for use of floors 1 and 2 in the new building such as exclusive use for physicians of Gastrointestinal Associates, PC.

Plans for all three floors are as follows:

Floor 1: Gastrointestinal Associates, P.C. will utilize this floor. It will contain a comprehensive weight management center, infusion suites, clinical trials spaces, medical records, human resources, staff kitchen and break area, and storage, and possibly other functions.

Floor 2: The Endoscopy Center of Knoxville, the licensed ASTC applying for the CON to relocate to this location.

Floor 3: Gastrointestinal Associates, P.C. will operate its medical practice on this floor, except for support activities listed above for the first floor. This will include management and physician offices as well as clinical practice rooms.

2. Section A, Applicant Profile, Item 5

The applicant's management services agreement effective in 1992 with AmSurg is noted. Was there a change in the management of the ASTC prior to that time from its original licensure by TDH in July 1986? Please provide a brief discussion of AmSurg's historical relationship with the applicant ASTC. In your response, please also identify the sites AmSurg manages in Tennessee.

AmSurg entered the relationship in 1992, as the document showed. AmSurg had no management or ownership interest in this facility, and no relationship with GIA (the medical practice) prior to that time. GIA itself managed its own endoscopy center.

A list of AmSurg facilities in Tennessee is provided following this page.

Knoxville	Knoxville	Nashville	Maryville	Knoxville	Chattanooga	Columbia	Columbia	Kingsport	Goodlettsville	Powell	Hermitage
865-588-5121	865-588-5121	615-250-4108	865-983-0073	865-588-1037	423-698-3999	931-388-3488	931-381-7818	423-247-2022	615-859-3121	865-588-5121	615-316-3066
The Endoscopy Center	The Endoscopy Center - West	St. Thomas Medical Group Endoscopy Center	Tennessee Endoscopy Center	Eye Surgery Center of East Tennessee	Chattanooga Endoscopy Center	The Surgery Center of Middle Tennessee	Mid-South Endoscopy Center	The Regional Eye Surgery Center	LVC Outpatient Surgery Center	The Endoscopy Center North	Associated Endoscopy
Knoxville Gi	Knoxville West Gi	St Thomas Gl	Marvville GI	Knoxville Eve	Chattanooga Gl	Middle Tennessee Multispecialty	Columbia TN GI	Kingsport Eve	Nashville-Rivergate TN Eve	Knoxville North TN GI	Hermitage TN GI

2001-002 2003-001 2007-001 2018-001 2063-001 2114-001 2120-001 2168-001 2213-001

Tennessee 2001-001

#### **SUPPLEMENTAL #1**

August 25, 2015 1:12 pm

9162515 N.L.T.S

Page Three August 21, 2015

#### 3. Section B, Project Description, Item 1

Please provide the following additional information for the highlights noted in the executive summary:

a. It appears that physicians on the applicant's medical staff may also hold privileges at 2 other ASTCs in Knox County owned by the applicant (pages 12/42). It appears that these ASTCs were both licensed in 2005 and are located within 14 miles of the applicant's facility. What consideration was given, if any, as to the advantages/disadvantages of merging the facility into any of the other existing AmSurg Centers in Knoxville?

The two other ASTC's, which have only two procedure rooms each, were not acquired. They sought and received CON approval several years ago specifically to achieve wider geographic distribution of this particular practice's endoscopy services within Knox County. The goal was to provide quicker accessibility and convenience for the practice's patients who resided all across this large urban county. Consolidation is the opposite of what the medical staff and AmSurg intend to do in this service area.

b. In terms of resources noted in the executive summary and other parts of the application, please add a brief description about the medical staff, including where they practice in the service area by noting location of their private practices, and the name/location of other ASTCs and hospitals in the services where they hold staff privileges.

The medical staff of the facility are listed on the following page, along with their primary practice addresses. If this project is approved, all of them will have their primary practice office in the same building as the ASTC, in Dowell Springs.

In Knox County, they perform endoscopic surgery at The Endoscopy Center, The Endoscopy Center West, The Endoscopy Center North, Physicians Regional Medical Center, Tennova North, Fort Sanders Regional Medical Center, Thompson Cancer Center, and Parkwest Medical Center. Six GIA physicians have privileges at Jefferson Memorial Hospital, in Jefferson City (Jefferson County). One performs cases at Methodist Medical Center, Oak Ridge (Anderson County) and its hospital-based endoscopic surgery center.



Page Four August 21, 2015

Medica	The Endoscopy Center Il Staff and Current Office Location
Physician	Current Primary Office Address
Barry V. Maves	801 N. Weisgarber Road, Knoxville, TN 37909
Sarkis J. Chobanian	801 N. Weisgarber Road, Knoxville, TN 37909
Charles M. O'Connor	801 N. Weisgarber Road, Knoxville, TN 37909
Meade C. Edmunds	801 N. Weisgarber Road, Knoxville, TN 37909
John M. Haydek	801 N. Weisgarber Road, Knoxville, TN 37909
Maria B. Newman	801 N. Weisgarber Road, Knoxville, TN 37909
Raj I. Narayani	801 N. Weisgarber Road, Knoxville, TN 37909
Steven J. Bindrim	801 N. Weisgarber Road, Knoxville, TN 37909
Scott L. Wilhoite	801 N. Weisgarber Road, Knoxville, TN 37909
Johnny Altawil	801 N. Weisgarber Road, Knoxville, TN 37909
John M. Moore	801 N. Weisgarber Road, Knoxville, TN 37909
Jeffrey Gilbert	988 Oak Ridge Turnpike, Oak Ridge, TN 37830

Page Five August 21, 2015

c. The applicant notes action by Medicare between 2010-2013 to cease all ASTC space sharing arrangements and describes the significant impact to the facility as a result of same. If possible, please provide source information such as reference to directives, rules, or similar notices that can help facilitate a better understanding of the changes implemented by Medicare.

42 CFR416.44(a)(2) requires that "The ASC must have a separate recovery room and waiting area." This separation requirement was not enforced for some years by State Licensure agencies who conducted facility surveys on behalf of Medicare, and certified facilities for compliance with Medicare regulations. For this facility, that changed with the CMS survey conducted by the Tennessee Department of Health on October 4, 2012, and a subsequent citation on October 11, 2012 for not having such separations. The concept of separating the ASC from the practice by operating the former from 7 am to noon, and the latter from 1 pm to 6 pm, was accepted under a waiver from Medicare and the Tennessee Department of Health.

d. It appears that there are or will soon be 3 physicians without ownership interests in the LLC that will perform endoscopies at the facility. With 12,852 cases projected for Year 1, the average cases per physician amounts to approximately 1,071 cases per MD. Since one of the non-owners (Dr. Gilbert) estimates performing approximately 2,500 cases in Year 1, what opportunities might arise for him to be offered an ownership interest in the applicant LLC?

As with all physicians who have joined the GIA practice in the past, Dr. Gilbert will be evaluated over a two-year period, for contributions to gastroenterology care, professionalism, and compatibility with others in the practice. After a positive evaluation he will be offered partnership in the practice and the opportunity to acquire an ownership interest in the applicant LLC.

4. Section B, Project Description, Item II.A.

The description is noted. However, the Square Footage Chart accompanying the response for this item was omitted from the attachments. Please provide the chart that supports the size of the facility & related construction costs identified in other parts of the application, such as the Project Costs Chart.

The Chart is attached following this page.

SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART THE ENDOSCOPY CENTER KNOXVILLE

**************************************	Existing	Existing	Temporary	Proposed	<u>~</u> 8	Proposed Final Square Footage			Proposed Final Cost / SF	
A. Office Department	Location	SF	Location	Location	Renovated	New	Total	Renovated	New	Total
Public Reception/Wait				2nd	3,636		3,636	\$210.00		\$736,560.00
Business Office				2nd	1,162		1,162	\$180.00		\$209,160.00
Pre-Op				2nd	2,041		2,041	\$290.00		\$591,890.00
Post-Op				2nd	4,035		4,035	\$290.00		\$1,170,150.00
Support				2nd	2,731		2,731	\$200.00		\$546,200.00
Procedure Rms/Corridor				2nd	2,450		2,450	\$300.00		\$735,000.00
Out Building Support				outdoors	200		500	\$550.00		\$275,000.00
				1						
										At 1
										194 12
B. Unit/Dept. USF Sub-Total							16,555			\$4,263,990.00
C. Mechanical / Electrical USF				2nd			177	\$204.32		\$36,164.0 <b>}</b>
D. Circulation / Structure USF							included			5
E. Total USF							16,732			\$4,300,124.00

# AU 25/15 WILLS

Page Six August 21, 2015

#### 5. Section C, Need Item 1, Specific Criteria -ASTC

#### ASTC, Item 2

a. Hours of Operation - please include a description of how the proposed schedule in Year 1 compares to the facility's current schedule, given the restrictions related to meeting Medicare requirements for separation of space discussed in Section B of the application.

Current Operating Hours:

7 am to noon, Monday-Friday.

Hours at the New Site:

7 am to 5 pm, Monday-Friday.

b. Projected Surgical Hours – Please include a brief description of how the projected surgical hours in Year 1 compare to the existing facility's current status.

Available Annual Hours to Schedule (Subtracting an hour for lunch)

(1) At Current Location:

4 hours per day X 8 rooms = 32 schedulable hours per day 32 hours per day X 250 days = 8,000 available hours

(2) At Proposed Location:

8 hours per day X 6 rooms = 48 schedulable hours per day 48 hours per day X 250 days = 12,000 available hours

#### ASTC, Item 11.d.

Please provide an update on status of contract with the 4<sup>th</sup> MCO available in the service area. Does the MCO need more provider members for this type of facility?

The State TennCare office has not yet completed its review of rate sheets and the applicant does not know the reason for their delay. All other paperwork is approved and waiting. The MCO appears to want and need this facility as a contracted member.

Page Seven August 21, 2015

- 6. Section C, Need Item 5 and 6 (Applicant's Historical and Projected Utilization)
  - a. Review of the utilization data provided and comparison to the JAR revealed that the applicant sent a 6/30/15 written request to TDH to provide some correction to the 2014 JAR (correspondence included in the attachments). Please briefly explain the nature & scope of same and whether or not this may impact the utilization identified in the application.

During preparation of the CON application, the applicant discovered that AmSurg's internal records of cases at all three Knoxville Endoscopy Centers did not match those facilities' JAR reports for FYE's 2011-13. The data were rechecked and the JAR corrections in the Attachments were sent in to the TDOH. The application was prepared using the *corrected* case numbers--where fiscal year data was required. However, most of the tables in the application show calendar year case data (which the JAR's do not provide).

b. The historical & projected utilization related to utilization by members of the medical staff is noted. For the 12,852 projected cases in Year 1, the breakout appears to be as follows:

Existing 11 medical staff MD utilization = 9,752 cases

New physicians - Drs. Gilbert & Moore = 3,100 cases

Total year 1 = 12,852 total cases

Is this an accurate reflection of the projected utilization for Year 1 as addressed in these parts of the application?

Yes.

c. The comments on both pages 15 and 42 appear to indicate that Dr. Gilbert is bringing 2,200 current cases, including 600 cases from 2 Knox County ASTCs owned by the applicant, plus 300 new cases from normal growth between 2015 and 2017. However, the August 11, 2015 letter from Drs. Gilbert & Moore appears to indicate that the 600 cases from the 2 other Knox County ASTCs will be transferred by Dr. Moore. Please clarify.

In the third sentence of the third paragraph of each page, the original sentence read: "....CY 2017. *Dr. Matthew Moore will bring 900 cases*--600 cases being currently performed...." Through an editing error the reference to Dr. Moore was deleted on both pages 15 and 42 (the latter having been copied from the prior). Attached after this page are revised pages 15R and 42R, with the deleted words re-inserted so that the sentence makes sense and states the physicians' cases clearly.

way. In the new location, a separate ambulance entry is provided, giving patients more privacy. And in the new design, families whose patients have been taken to surgery will wait for them in a second waiting area that is separate from the one for arriving patients and families. Discharge after recovery will be more private, with patient exits separated from the view of the waiting rooms. Airlocks will be provided for all-weather comfort and privacy in exiting the building, and for arriving ambulance patients.

#### Need For Six Procedure Rooms (Decrease of Two Rooms)

The facility's annualized CY2015 utilization based on January-June is 9,560 cases. In CY2016, at the current location, facility management projects that normal growth in physician referrals will increase utilization by at least 1%, to 9,656 cases. In CY2017, even at the current location, normal growth brought by existing medical staff will again increase utilization by 1%, to 9,752 cases.

But if the proposed relocation is approved, allowing normal full-day operation, an *additional* 3,100 new cases will be brought to the new location in CY2017 by two physicians who currently do not have room to perform their cases at this facility. Dr. Jeff Gilbert, an established Anderson County gastroenterologist, is joining the Center in late 2015. He projects bringing 2,200 of his current cases to the new location in CY2017. Dr. Matthew Moore will bring 900 cases--600 cases currently being performed at two Knox County endoscopy centers owned by this same applicant, plus 300 new cases from normal practice growth between 2015 and 2017. Dr. Gilbert's and Dr. Moore's letter attesting to these new cases are provided in the Attachments.

In CY2017, with a normal full-day surgical schedule resumed at the new location, and with Dr. Gilbert and Dr. Moore's transferred cases, The Endoscopy Center projects a first-year caseload of 12,852 cases. The following year the Center projects a continuing 1% increase in utilization, to 12,981 cases.

Table Three-A below shows that the projected occupancy on the proposed facility is consistent with the Guidelines of the State Health Plan. The Table shows surgical room utilization as a percent of three standards: (a) Amsurg's broad general goal

#### SUPPLEMENTAL #1

August 25, 2015 1:12 pm

The sudden reduction of *effective* surgical capacity by a required closure at noon, and the death of the center's busiest surgeon (who performed approximately 1,500 cases per year), caused the center's utilization to decline the following year by 15%--from 11,251 cases in CY2013 to a projected 9,560 cases in CY2015. With additional physician recruitment since 2013, utilization is slowly increasing, but the limitation to half-day operation is a severe restraint on case referrals to this practice and to its ASTC.

The facility's annualized CY2015 utilization based on January-June is 9,560 cases. In CY2016, at the current location, facility management projects that normal growth in physician referrals will increase utilization by at least 1%, to 9,656 cases. In CY2017, even at the current location, normal growth brought by existing medical staff will again increase utilization by 1%, to 9,752 cases.

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Table Three-A below shows that the projected occupancy on the proposed facility is consistent with the Guidelines of the State Health Plan. The Table shows surgical room utilization as a percent of three standards: (a) Amsurg's broad general goal of performing 2,500 cases per room; (b) the State Health Plan's "optimal" goal of 1,867

Page Eight August 21, 2015

d. The 2,500 projected cases by Dr. Gilbert amount to approximately 9.6 cases per day, based on 5 days per week/52 weeks per year. Please briefly describe how that level is realistic. In your response, please provide a breakout of the projected volumes by each physician of the medical staff for Year 1.

The applicant is not authorized to disclose individual physicians' case volumes because that is sensitive and proprietary practice information of each physician. Dr. Gilbert's and Dr. Moore's cases were disclosed with their permission, because they are new case commitments that must be quantified and documented to support the utilization projections and financial feasibility of the project.

Dr. Gilbert does in fact perform 2,200 cases per year. This is not unusual for an established gastroenterologist. Many physicians in this facility also perform cases at its two sister facilities (North and West). They average more than 2,100 cases per year at the three locations combined. And they perform additional inpatient cases at area hospitals.

Physician case times vary greatly. At this facility, on average, they take up to 35 minutes per case. At that rate, ten of them can be performed in less than six hours in one room. This staff will have six rooms at its disposal. A time analysis for the projected case volumes was provided on page 25 of the application, validating that there is sufficient time for these cases to be performed.

7. Section C, Economic Feasibility, Item 2 (Funding)

The August 10, 2015 letter from the CFO of AmSurg is noted. However, the loan schedule was omitted from the attachment. Please provide the schedule that supports the lease cost in the Project Cost Chart and the Projected Data Chart.

An amortization schedule is attached following this page. Also attached is a revised page 53R, the Projected Data Chart, with minor adjustments in the Line F Capital Expenditure data to correspond exactly with the amortization schedule.

#### **SUPPLEMENTAL #1**

#### Combined Notes

August 25, 2015 1:12 pm

#### 2001-001 Knoxville GI

TOTAL FINANCED	6,681,000
Number of years	10
Annual Interest Rate Annual Payment	5.0% 865,220

		Principal
Inception		\$ 6,681,000
End Of Yr.	1	\$ 6,149,830
End Of Yr.	2	\$ 5,592,101
End Of Yr.	3	\$ 5,006,486
End Of Yr.	4	\$ 4,391,591
End Of Yr.	5	\$ 3,745,950
End Of Yr.	6	\$ 3,068,028
End Of Yr.	7	\$ 2,356,209
End Of Yr.	8	\$ 1,608,799
End Of Yr.	9	\$ 824,019
End Of Yr.	10	\$ 0
End Of Yr.	11	\$ 0

LEV	EL	TOTAL PAYMENTS		
Principal Pmt.		Interest	Tota	al Payment
\$ 531,170	\$	334,050	\$	865,220
\$ 557,729	\$	307,491	\$	865,220
\$ 585,615	\$	279,605	\$	865,220
\$ 614,896	\$	250,324	\$	865,220
\$ 645,641	\$	219,580	\$	865,220
\$ 677,923	\$	187,298	\$	865,220
\$ 711,819	\$	153,401	\$	865,220
\$ 747,410	\$	117,810	\$	865,220
\$ 784,780	\$	80,440	\$	865,220
\$ 824,019	\$	41,201	\$	865,220
\$ 121	\$	(#3,	\$	<u>/₩</u>
\$ 6,681,000	\$	1,971,201	\$	8,652,201

#### **SUPPLEMENTAL #1**

# PROJECTED DATA CHART— THE ENDOSCOPY CENTER (KNOW) 25, 2015 (REVISED ON SUPPLEMENTAL CYCLE) 1:12 pm

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January.

					CY 2017		CY 2018
A.	Utiliz	ation Data	Cases		12,852		12,981
В.	Reve	nue from Services to Patients					
	1.	Inpatient Services		<b>\$</b> _		\$	
	2.	Outpatient Services		-	23,474,349		23,946,184
	3.	Emergency Services				_	
	4.	Other Operating Revenue (Spec	cify) See notes page	-			
			<b>Gross Operating Revenue</b>	\$_	23,474,349	\$_	23,946,184
C.	Dedu	actions for Operating Revenue					
	1.	Contractual Adjustments		\$	15,026,121	\$_	15,398,236
	2.	Provision for Charity Care			1,344,498	-	1,371,522
	3.	Provisions for Bad Debt		-	164,072	_	167,370
			<b>Total Deductions</b>	\$_	16,534,691	\$_	16,937,128
NET	OPER	ATING REVENUE		\$_	6,939,659	\$_	7,009,056
D.	Ope	rating Expenses					
	1.	Salaries and Wages		\$_	2,815,444	\$_	2,871,753
	2.	Physicians Salaries and Wages		)=		-	0
	3.	Supplies		_	648,702	-	661,676
	4.	Taxes		_	220,741		225,156
	5.	Depreciation			631,955		631,955
	6.	Rent			470,027	=	479,428
	7.	Interest, other than Capital			(449)		(458)
	8.	Management Fees					0
		a. Fees to Affiliates			50,000		51,000
		b. Fees to Non-Affiliates					0
	9.	Other Expenses (Specify)	See notes page		1,150,144		1,173,147
		Dues, Utilities, Insurance, and Prop Taxes.					
			<b>Total Operating Expenses</b>	\$	5,986,564	\$	6,093,656
E.	Oth	ner Revenue (Expenses) Net (S	Specify)	\$		\$	
		RATING INCOME (LOSS)		\$	953,095	\$	915,399
F.		pital Expenditures					
١.	1.	Retirement of Principal		\$	531,170	\$	557,729
	2.	Interest			334,050		307,491
			Total Capital Expenditures	\$	865,220	\$	865,220
NE	T OPE	RATING INCOME (LOSS)					
		PITAL EXPENDITURES		\$	87,875	\$	50,179_
						-	

Page Nine August 21, 2015

- 8. Section C. Economic Feasibility Item 4, Historical and Projected Data Charts The charts are noted. Please address the items below:
  - a. Historical Data Chart the entries for taxes (Line D.4) and capital expenditures (Lines F.1 and F.2) appear to differ from the amounts shown in the applicant's Statement of Earnings for the period ending 12/31/15. As a result, Net operating income in the Chart appears to be understated. Please explain.

To follow the AmSurg calculations, please utilize the Historic Data Chart and also the ASTC's 2014 Statement of Earnings and 2014 Balance Sheet. The latter two are attached after this page, marked up for convenient reference.

#### Taxes

In CY 2014, the Historic Data Chart shows taxes of \$174,364 in line D4. The facility's CY 2014 Statement of Earnings contains two entries for taxes, which total \$174,364. The tax entries are circled on the Statement.

#### Capital Expenditures

In CY 2014, the Historic Data Chart shows a total of \$151,872 capital expenditures--consisting of principal retirement (\$149,556) and interest (\$2,316).

The facility's CY 2014 Balance Sheet shows a CY2013 principal of \$149,556 being paid off entirely in CY2014. So the Historic Data Chart correctly recorded principal retirement consistent with the Balance Sheet.

The facility's CY 2014 Statement of Earnings shows an interest amount of \$1,867. The Historic Data Chart line D7 shows an interest amount of \$449. Their total is \$2,316. It is shown in line F2 of the Historic Data Chart.

E02 IS Centers
Date as of MAY 26, 2015 at 8:36 a.m.

#### 2001-001 Knoxville Gl

August 25, 2015 1:12 pm

Page 1

# Statement of Earnings For the Period Ending December 31, 2014

	Monthly Actual	Monthly Budget	Prior Month	YTD Actual	YTD Budget	YTD Prior Year
Gross charges:						
GI revenue	1,800,484	1,454,002	1,397,248	17,454,957	17,136,013	20,400,296
Total gross charges	1,800,484	1,454,002	1,397,248	17,454,957	17,136,013	20,400,296
Estimated reserves:						
Contractual adjustments	1,243,137	1,002,480	983,485	12,064,650	11,809,853	14,100,654
Bad debt expense	12,603	11,632	9,781	217,185	137,089	192,802
Total estimated adjustments	1,255,740	1,014,112	993,266	12,281,835	11,946,942	14,293,456
Net revenue	544,744	439,890	403,983	5,173,122	5,189,071	6,106,840
Operating expenses:						
Salaries and benefits	221,587	241,351	175,401	2,407,309	2,896,212	2,878,240
Medical supplies and drugs	49,156	41,359	37,318	480,012	487,432	581,418
Other variable expenses	61,306	65,850	52,545	731,500	853,200	836,271
Fixed expenses	22,248	22,928	20,052	250,278	274,623	261,947
Operating taxes	2,023	3,220	1,430	36,022	38,640	39,701
Depreciation	19,891	18,671	19,172	231,163	227,312	238,173
Total operating expenses	376,211	393,379	305,919	4,136,283	4,777,419	4,835,750
Operating income	168,533	46,511	98,064	1,036,839	411,652	1,271,091
Other income and (expense):						
Interest expense, net	68	7	0	(1,867)	(2,230)	(8,082)
Fees and other	323	279	94	4,378	3,348	5,304
Earnings before income taxes	168,924	46,797	98,159	1,039,349	412,770	1,268,312
Income tax expense	18,214	11,875	14,420	138,342	97,859	146,418
Net earnings	150,710	34,922	83,738	901,007	314,911	1,121,894

TUT. TAYES \$174,364 (138,342)

#### **SUPPLEMENTAL #1**

August 25, 2015 1:12 pm

Page 1

E01 Balance Sheet Centers
Data as of MAY 26, 2015 at 8:36 a.m.

#### 2001 Knoxville GI

#### Balance Sheets December 31, 2014

	/				
	Dec 2014	Nov 2014	Increase (Decrease)	Dec 2013	Increase (Decrease)
ASSETS					
Current assets:					
Cash and cash equivalents	533,662	485,924	47,739	310,859	222,804
Accounts receivable: Accounts receivable gross	2,298,483	1,981,154	317,329	2,031,102	267,381
Contractual allowance	(1,386,043)	(1,138,568)	(247,475)	(1,063,546)	(322,497)
Bad debt allowance	(92,751)	(66,844)	(25,907)	(143,767)	51,016
Accounts receivable, net	819,689	775,741	43,948	823,789	(4,100)
Other receivables	39,039	22,947	16,091	22,963	16,075
Supplies inventory	100,604	109,632	(9,028)	109,632	(9,028)
Prepaid and other current assets	43,482	40,586	2,896	40,946	2,536
Total current assets	1,536,475	1,434,830	101,645	1,308,188	228,287
Property and equipment:				4.044.704	0
Building improvements	1,244,784	1,244,784	0 21,666	1,244,784 3,512,734	0 72,512
Equipment	3,585,246	3,563,580			
	4,830,030	4,808,364	21,666 (22,873)	4,757,518 (3,695,632)	72,512 (272,553)
Accumulated depreciation	(3,968,186)	(3,945,312)		-	
Property and equipment, net	861,844	863,051	(1,207)	1,061,885	(200,041)
Intangible assets:	4.400.440	4 400 440	0	4,199,118	0
Goodwill, net	4,199,118 52,078	4,199,118 45,249	6,829	59,862	(7,783)
Other intangibles Intangible assets, net	4,251,196	4,244,367	6,829	4,258,979	(7,783)
•	6,649,515	6,542,248	107,267	6,629,052	20,463
Total assets	0,043,013	0,042,240	107,207	Olorology	
LIABILITIES AND EQUITY					
Current liabilities:	004404	005.070	(4.706)	236,263	47,871
Accounts payable	284,134 9,901	285,870 27,185	(1,736) (17,285)	2,749	7,152
Current income taxes payable Accrued salaries and benefits	204,526	165,914	38,612	226,494	(21,968)
Other accrued liabilities	0	1,624	(1,624)	0	0
Intercompany payable (receivable)	4,279	7,391	(3,112)	5,398	(1,119)
	502,839	487,985	14,854	2013 BUN /	31,936
Long-term debt	0	0	0	149,556	(149,556)
Other long-term liabilities	165,526	165,614	(88)	182,942	2,584
Equity:	4 === ===	0.000.040	AT ATT	0.004.000	60 105
GP capital account	3,050,387	3,003,212 2,885,438	47,175 45,325	2,981,282 2,864,369	69,105 66,395
LP capital account	2,930,763	1.5 -5 -5 10000000000000000000000000000000			
		E 000 0E0	OO FOR		
Total equity	5,981,150 6,649,515	5,888,650 6,542,248	92,501 107,267	5,845,651 6,629,052	135,500 20,463

#### **SUPPLEMENTAL #1**

August 25, 2015 1:12 pm

Page Ten August 21, 2015

b. Review of the "Other Expenses" detail shows increases in contract services and maintenance of scopes. With 2 less procedure rooms at the new location what accounts for these?

Most of the endoscopes at the current location will be brought over to the new location. They are already old, and they will require increasing service and maintenance, in AmSurg's experience.

9. Section C, Economic Feasibility, Item 6.B.

The comparison of charges to other facilities is noted. The applicant's utilization is shown as 8,402 cases in FYE 2014. However, the utilization for FY2014 appears to be shown as 9,953 cases on page 39 and in the provider JAR. Please explain. If in error, please revise the table and submit a replacement page 55-R with your response.

Thank you for noticing that. The 8,402 cases are unduplicated patients, some of whom came back during the year for additional procedures. The 9,953 cases are the actual cases performed, as shown in the amended JAR and on page 39 of the application.

Attached after this page is a revised page 55R correcting the table. This makes the average charge data more consistent with the 2017 data shown immediately thereafter.

10. Section C, Orderly Development, Item 2

The analysis of impact is noted. This response and the attached letter from the 2 physicians states that Dr. Moore will transfer 600 cases from the other 2 AmSurg facilities in Knoxville. However, please note that the narrative on pages 15 and 42 indicates these cases may be transferred by Dr. Gilbert. Please clarify.

As stated in prior response 6(c), Dr. Moore will transfer the 600 cases. Pages 15 and 42 mistakenly deleted part of the sentence that had originally stated that Dr. Moore was the one moving the 600 cases.

**August 25, 2015** 

1:12 pm

C(II).6.B. COMPARE THE PROPOSED CHARGES TO THOSE OF SIMILAR FACILITIES IN THE SERVICE AREA/ADJOINING SERVICE AREAS, OR TO PROPOSED CHARGES OF PROJECTS RECENTLY APPROVED BY THE HSDA. IF APPLICABLE, COMPARE THE PROJECTED CHARGES OF THE PROJECT TO THE CURRENT MEDICARE ALLOWABLE FEE SCHEDULE BY COMMON PROCEDURE TERMINOLOGY (CPT) CODE(S).

Table Ten below compares the applicant's <u>FYE 2014 and CY 2017</u> charges to the <u>FYE 2014</u> charges of Nashville, Knoxville, and Maryville endoscopy centers.

Table Ten: Applicant's Charges in <u>CY</u> 2017 Compared to <u>FYE</u> 2014 Charges at Dedicated Endoscopy Centers in Knoxville and Nashville							
	Cases	-	Gross Charges		Net Revenue		
Facility	(Patients)	Gross Charges	Per Case	Net Revenue	Per case		
Digest. Disease Endo. Center (Nashville)	6,162	\$9,148,179	\$1,485	\$5,242,063	\$851		
Nashville Endo. Center (Nashville)	2,870	\$11,209,263	\$3,906	\$2,128,551	\$742		
The Applicant FYE 2014	9,953	\$17,668,336	\$1,775	\$5,367,724	\$539		
The Applicant CY 2017	12,852	\$23,474,349	\$1,827	\$6,939,659	\$540		
The Endoscopy Center West (Knox)	4,193	\$8,937,499	\$2,132	\$2,501,911	\$597		
Associated Endoscopy (Nashville)	5,031	\$8,220,082	\$1,634	\$2,902,350	\$577		
The Endoscopy Center North (Knoxville)	5,353	\$11,650,650	\$2,176	\$3,018,963	\$564		
NV GI Endo. Center (Nashville)	2,594	\$2,748,480	\$1,060	\$1,210,816	\$467		
Mid-State Endo. Center (Nashville)	2,436	\$2,697,619	\$1,107	\$1,108,610	\$455		
Southern Endo. Center (Nashville)	2,711	\$2,707,995	\$999	\$1,153,111	\$425		
Tennessee Endoscopy Center (Maryville)	7,081	\$9,505,355	\$1,342	\$2,553,941	\$361		

Source: 2014 Joint Annual Reports of ASTC's and Projected Data Chart, this project.

The following page contains Table Eleven, showing the applicant's most frequent procedures performed, with their current Medicare reimbursement, and their projected Year One and Two average gross charges.



Page Eleven August 21, 2015

#### 11. Affidavit

The affidavit appears to have been omitted from the application delivered to HSDA office on 8/14/15. Please provide same.

This is attached at the end of this letter along with the affidavit for this supplemental response.

Thank you for your assistance. We hope this provides the information needed to accept the application into the next review cycle. If more is needed please email or telephone me so that we can respond in time to be deemed complete.

John Wellborn

John Wellborn Consultant

August 25, 2015 1:12 pm



SUPCORPORATEORICEA KNOWVILLE

August 25, 2015 noxville, TN 37919 1:12 pm 865,521.0630

> ATLANTA 1100 Johnson Ferry Road Building 1 – Suite 400 Atlanta, GA 30342 404.402.5503

August 21, 2015

Ms. Kimberly Walsh
Division Vice President, Operations
AMSURG Corporation
1A Burton Hills Boulevard
Nashville, Tennessee 37215

### RE: The Endoscopy Center of Knoxville - CON Application to Relocate

Dear Kimberly:

As of the application date, the recorded owner of the Property (Lot 4R3 as further described in the Option to Sublease previously submitted with the application and attached hereto) is RTG Dowell Springs, LLC ("RTG") The plan of syndication and development of the Project contemplates that RTG will convey the Property, prior to construction of the Project, to DDC Dowell Springs, LLC, a Tennessee limited liability company ("DDC"), which has, prior to the application date, been duly formed. As of the application date, DDC is wholly owned by RTG, which is DDC's sole member. Upon transfer of the Property from RTG to DDC, DDC will construct the Project and will lease the entire Building to the Master Tenant, who will in turn sublease the Center to the Endoscopy Subtenant.

The purpose of naming both RTG and DDC as "Owner" in the Option to Sublease is to make clear that the rights of the Master Tenant and the Endoscopy Subtenant are recognized and legally respected by both RTG and DDC.

Sincerely,

Gregory P. Gheen

President

Enclosure

cc: John Wellborn, Development Support Group

Jeff Dew, Gastrointestinal Associates, P.C.

M. Douglas Campbell, Jr., Wagner, Myers & Sanger, P.C.

106 DAFOLD POR OTAL #1

August 25, 2015 1:12 pm

OWNER/RESPONSIBLE TAXPAYER: RTG Dowell Springs, LLC 2220 Sutherland Avenue Knoxville, TN 37919 ATTN: GREG GHEEN Map 106D, Group A, Parcel 009.02 THIS INSTRUMENT PREPARED BY:
TENNESSEE VALLEY TITLE INSURANCE CO.
800 South Gay Street, Suite 1700
Knoxville, TN 37929
File No. 141351 (RPM)

Sherry Witt Register of Deeds Knox County

# WARRANTY DEED

THIS INDENTURE made as of this 19th day of June, 2015, between DOWELL SPRINGS COMPANY, a Tennessee general partnership, First Party, and RTG DOWELL SPRINGS, LLC, a Tennessee limited liability company, Second Party:

### WITNESSETH

THAT SAID FIRST PARTY, for and in consideration of the sum of TEN AND NO/100 (\$10.00) DOLLARS, and other good and valuable consideration, to it in hand paid by said Second Party, the receipt of which is hereby acknowledged, has granted, bargained, sold and conveyed, and does by these presents grant, bargain, sell and convey unto Second Party, the real property described as follows:

# SEE EXHIBIT "A" ATTACHED HERETO AND MADE A PART HEREOF

With the hereditaments and appurtenances thereto appertaining, hereby releasing all claims therein. TO HAVE AND TO HOLD the same unto the Second Party, its successors and assigns forever.

AND SAID FIRST PARTY, for itself and its successors and assigns, does hereby covenant with said Second Party, its successors and assigns, that it is lawfully seized in fee simple of the premises above conveyed and has full power, authority and right to convey the same, and that said premises are free from all encumbrances except the matters set forth on Exhibit "B" attached hereto and made a part hereof, and 2015 taxes, which taxes shall be prorated between said First Party and said Second Party as of the date of closing (the "Encumbrances") and which Encumbrances Second Party assumes and which prorated taxes said Second Party and said First Party agree to pay, and that said First Party will forever warrant and defend the said premises and the title thereto against the lawful claims of all persons whomsoever, except as to the Encumbrances.

Whenever in this instrument a pronoun is used it shall be construed to represent either singular or plural, or the masculine, feminine or neuter gender, as the case may demand.

Knox County Page: 1 of 5 REC'D FOR REC 06/19/2015 11:53:55AM RECORD FEE: \$28.00

M. TAX: \$0.00 T. TAX: \$3,681.60 201506190069909 COUNTERSIGNED KNOX COUNTY PROPERTY ASSESSOR

JUN 1 9 2015 PHIL BALLACE

H:\sforte\141351 RTG Dowell Springs, LLC\WD DSC to RTG (Lot 4R2).doc

August 25, 2015 1:12 pm

IN WITNESS WHEREOF, the said First Party hereunder has caused this instrument to be executed as of the day and year first above written.

DOWELL SPRINGS COMPANY, a Tennessee general partnership

By: White Realty and Service Corporation, a

Tennessee Corporation, Partner

ly: X

Title: Executive Vice President

STATE OF TENNESSEE )
) SS
COUNTY OF KNOX )

PERSONALLY appeared before me, the undersigned authority, a Notary Public in and for said County and State, JERRY L. BODIE, with whom I am personally acquainted, or proved to me on the basis of satisfactory evidence, and who, upon oath, acknowledged himself to be the Executive Vice President of WHITE REALTY AND SERVICE CORPORATION, a Partner of DOWELL SPRINGS COMPANY, Tennessee general partnership, the within named bargainor, and that he as such Executive Vice President, being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the partnership by himself as such Executive Vice President of the Partner.

WITNESS my hand and official seal of office this 4 day of June, 2015.

My Commission Expires: 8/5//

Page: 2 0F 5 201506190069909

August 25, 2015 1:12 pm

I nereby swear of affirm that the actual consideration of the value of this transfer,
whichever is greater, is \$ 995,000 -
/2//
1-11/62
Affiant
ch.
Subscribed and sworn to before me this 19th day of June, 2015.
1/1/61
Citale XVV
Mounty: Public
My Commission Expires: 8/5/18
SUL STATE
OF OF
TENNESSEE OF
NOTARY
A PUBLICATION OF THE PUBLICATION
MOX COURT
William III

Page: 3 OF 5 201506190069909



### **EXHIBIT "A"**

SITUATE in the Fifth (5th) Civil District of Knox County, Tennessee, within the 45th Ward of the City of Knoxville, Tennessee, being all of Lot 4R2 as shown on plat of Resubdivision of Part of Lot 4 Dowell Springs, dated November 11, 2002, filed for record as Instrument No. 200305010099379 in the Knox County Register of Deeds Office, to which plat specific reference is hereby made for a more particular description of said lot.

BEING a portion of the same property conveyed to Dowell Springs, L.L.C., a Tennessee limited liability company, by Warranty Deed from Irene M. Meadows (a/k/a Irene Wright Meadows), widow, individually and as sole beneficiary of the Estate of Leonel E. Meadows, dated August 20, 1998, filed for record in Warranty Book 2297, page 313 in the Knox County Register of Deeds Office. Dowell Springs, L.L.C., a Tennessee limited liability company, merged with and into Dowell Springs Company, a Tennessee general partnership, pursuant to Certificate of Merger dated December 21, 1999, filed for record as Instrument No. 200001060001267 in the Knox County Register of Deeds Office.



### EXHIBIT "B"

- Right of way and easement granted to Plantation Pipe Line Company, a Delaware corporation, by J.D. Dowell, Mary Dowell and Charlie Dowell, by instrument dated August 18, 1941, filed for record in Warranty Book 601, page 499 in the Knox County Register of Deeds Office.
- 2. Development Agreement by and between Dowell Springs L.L.C., a Tennessee limited liability company, and Plantation Pipe Line Company, a Delaware and Virginia corporation, dated December 3, 1998, filed for record as Instrument No. 200001240004832 in the Knox County Register of Deeds Office.
- 3. Permanent Maintenance Agreement for Storm Water Facilities by and between the City of Knoxville and Dowell Springs Company, dated January 26, 2000, filed for record as Instrument No. 200002090008392 in the Knox County Register of Deeds Office.
- 4. Agreement by and between the City of Knoxville and Dowell Springs Company, a Tennessee general partnership, dated February 28, 2000, filed for record as Instrument No. 200002290013013 in the Knox County Register of Deeds Office.
- 5. Grant of Permanent Drainage Easements from Dowell Springs Company, a Tennessee general partnership, to the City of Knoxville, dated February 23, 2001, filed for record as Instrument No. 200103070058835 in the Knox County Register of Deeds Office.
- 6. Declaration of Protective Covenants, Conditions, Restrictions and Owners' Association for Dowell Springs, dated January 1, 2001, filed for record as Instrument No. 200103090059374 in the Knox County Register of Deeds Office.
- 7. Covenants for Permanent Maintenance of Stormwater Facilities made by Dowell Springs, LLC, dated October 21, 2004, filed for record as Instrument No. 200410210033733 in the Knox County Register of Deeds Office.
- 8. Matters depicted and disclosed by Final Plat of Dowell Springs Resubdivision of Lots 4R1, 4R2, 4R6, and J.P.E. Meadowgreen Way, dated April 27, 2015, filed for record as Instrument No. 201506190669107 in the Knox County Register of Deeds Office.



SUP 1990/#1 August 25, 2015 1:12 pm

OWNER/RESPONSIBLE TAXPAYER: RTG Dowell Springs, LLC 2220 Sutherland Avenue Knoxville, TN 37919 ATTN: GREG GHEEN Map 106D, Group A, Parcel 009.01 THIS INSTRUMENT PREPARED BY:
TENNESSEE VALLEY TITLE INSURANCE CO.
800 South Gay Street, Suite 1700
Knoxville, TN 37929
File No. 141351 (RPM)

Sherry Witt Register of Deeds Knox County

WARRANTY DEED

THIS INDENTURE made as of this \_\_\_\_\_\_\_ day of June, 2015, between HOME FEDERAL BANK OF TENNESSEE, First Party, and RTG DOWELL SPRINGS, LLC, a Tennessee limited liability company, Second Party:

### WITNESSETH

THAT SAID FIRST PARTY, for and in consideration of the sum of TEN AND NO/100 (\$10.00) DOLLARS, and other good and valuable consideration, to it in hand paid by said Second Party, the receipt of which is hereby acknowledged, has granted, bargained, sold and conveyed, and does by these presents grant, bargain, sell and convey unto Second Party, the real property described as follows:

# SEE EXHIBIT "A" ATTACHED HERETO AND MADE A PART HEREOF

With the hereditaments and appurtenances thereto appertaining, hereby releasing all claims therein. TO HAVE AND TO HOLD the same unto the Second Party, its successors and assigns forever.

AND SAID FIRST PARTY, for itself and its successors and assigns, does hereby covenant with said Second Party, its successors and assigns, that it is lawfully seized in fee simple of the premises above conveyed and has full power, authority and right to convey the same, and that said premises are free from all encumbrances except the matters set forth on Exhibit "B" attached hereto and made a part hereof, and 2015 taxes, which taxes shall be prorated between said First Party and said Second Party as of the date of closing (the "Encumbrances") and which Encumbrances Second Party assumes and which prorated taxes said Second Party and said First Party agree to pay, and that said First Party will forever warrant and defend the said premises and the title thereto against the lawful claims of all persons whomsoever, except as to the Encumbrances.

Whenever in this instrument a pronoun is used it shall be construed to represent either singular or plural, or the masculine, feminine or neuter gender, as the case may demand.

Knox County Page: 1 of 5
REC'D FOR REC 06/19/2015 11:52:40AM

RECORD FEE: \$29.00
M. TAX: \$0.00 T. TAX: \$3,385.50
201506190069908

JUN 1 9 2015

KNOX COUNTY PROPERTY ASSESSOR

PHIL BALLARIO

August 25, 2015 1:12 pm

IN WITNESS WHEREOF, the said First Party hereunder has caused this instrument to be executed as of the day and year first above written.

	HOME FEDERAL BANK OF TENNESSEE  By: Alale A. Keasling  Title: President + CEO
STATE OF TENNESSEE ) COUNTY OF Knox )	
acquainted, or proved to me on the basis acknowledged him self to be the Pres BANK OF TENNESSEE, the within President & CEO, being authorized so to	of satisfactory evidence, and who, upon oath, ident & CEO. of HOME FEDERAL named bargainor, and that _he as such odo, executed the foregoing instrument for the the name of the bank by himself as such
WITNESS my hand and official se	al at office this 19 day of June, 2015.
My Commission Expires: 2-4-2018	Carolini hove Notary Public
STATE OF TENNESSEE NOTARY PUBLIC	Page: 2 of 5 201506190069908

August 25, 2015 1:12 pm

### **EXHIBIT "A"**

SITUATE in the Fifth (5th) Civil District of Knox County, Tennessee, within the 45th Ward of the City of Knoxville, Tennessee, being all of Lot 4R1 as shown on plat of Resubdivision of Part of Lot 4 Dowell Springs, dated November 11, 2002, filed for record as Instrument No. 200305010099379 in the Knox County Register of Deeds Office; to which plat specific reference is hereby made for a more particular description of said lot.

**BEING** the same property conveyed to Home Federal Bank of Tennessee by Corporation Warranty Deed from Dowell Springs Company, a Tennessee general partnership, dated July 10, 2003, filed for record as Instrument No. 200307100004486 in the Knox County Register of Deeds Office.



# **EXHIBIT "B"**

- Right of way and easement granted to Plantation Pipe Line Company, a Delaware corporation, by J.D. Dowell, Mary Dowell and Charlie Dowell, by instrument dated August 18, 1941, filed for record in Warranty Book 601, page 499 in the Knox County Register of Deeds Office.
- Development Agreement by and between Dowell Springs L.L.C., a Tennessee limited liability company, and Plantation Pipe Line Company, a Delaware and Virginia corporation, dated December 3, 1998, filed for record as Instrument No. 200001240004832 in the Knox County Register of Deeds Office.
- 3. Permanent Maintenance Agreement for Storm Water Facilities by and between the City of Knoxville and Dowell Springs Company, dated January 26, 2000, filed for record as Instrument No. 200002090008392 in the Knox County Register of Deeds Office.
- Agreement by and between the City of Knoxville and Dowell Springs Company, a Tennessee general partnership, dated February 28, 2000, filed for record as Instrument No. 200002290013013 in the Knox County Register of Deeds Office.
- Grant of Permanent Drainage Easements from Dowell Springs Company, a Tennessee general partnership, to the City of Knoxville, dated February 23, 2001, filed for record as Instrument No. 200103070058835 in the Knox County Register of Deeds Office.
- 6. Declaration of Protective Covenants, Conditions, Restrictions and Owners' Association for Dowell Springs, dated January 1, 2001, filed for record as Instrument No. 200103090059374 in the Knox County Register of Deeds Office.
- 7. Matters depicted and disclosed by plat of Resubdivision of Part of Lot 4 Dowell Springs dated November 11, 2002, filed for record as Instrument No. 200305010099379 in the Knox County Register of Deeds Office.
- 8. Covenants for Permanent Maintenance of Stormwater Facilities made by Dowell Springs, LLC, dated October 21, 2004, filed for record as Instrument No. 200410210033733 in the Knox County Register of Deeds Office.
- 9. Matters depicted and disclosed by Final Plat of Dowell Springs Resubdivision of Lots 4R1, 4R2, 4R6, and J.P.E. Meadowgreen Way, dated April 27, 2015, filed for record as Instrument No. 20156619604 in the Knox County Register of Deeds Office.



SUPPLEARE PAROTO

August 28,609 0002

OWNER/RESPONSIBLE TAXPAYER:

RTG Dowell Springs, LLC 2220 Sutherland Avenue Knoxville, TN 37919 ATTN: GREG GHEEN

Map 106D, Group A, Parcel 009.01 Map 106D, Group A, Parcel 009.02

Map 106D, Group A, Portion of Parcel 009.04

THIS INSTRUMENT PREPARED 1812 pm / OG DA 00904 TENNESSEE VALLEY TITLE INSURANCE CO. 800 South Gay Street, Suite 1700

Knoxville, TN 37929 File No. 141351 (RPM)

Sherry Witt Register of Deeds Knox County

# **QUITCLAIM DEED**

THIS INDENTURE made as of this 19/2 day of June, 2015, between DOWELL SPRINGS COMPANY, a Tennessee general partnership, First Party, and RTG DOWELL SPRINGS, LLC, a Tennessee limited liability company, Second Party:

### WITNESSETH:

THAT SAID FIRST PARTY, for and in consideration of the sum of ONE AND NO/100 (\$1.00) DOLLAR, and other good and valuable consideration, to it in hand paid by said Second Party, the receipt of which is hereby acknowledged, has bargained, sold, remised, released and QUITCLAIMED, and does by these presents bargain, sell, remise, release and QUITCLAIM unto Second Party all of First Party's right, title and interest in and to the following described premises, to-wit:

# SEE EXHIBIT "A" ATTACHED HERETO AND MADE A PART HEREOF

With the hereditaments and appurtenances thereto appertaining, hereby releasing all claims therein to the said Second Party, its successors and assigns forever.

Whenever in this instrument a pronoun is used it shall be construed to represent either singular or plural, as the case may demand.

> COUNTERSIGNED KNOX COUNTY PROPERTY ASSESSOR

> > JUN 1 9 2015

DOWELL SPRINGS COMPANY, a Tennessee general partnership

By: White Realty and Service Corporation, a Tennessee Corporation, Partner

Executive Vice President

REC'D FOR REC 06/19/2015 11:64:36AM RECORD FEE: \$17.00

M. TAX: \$0.00 T. TAX: \$0.00

201506190069910

		August 25, 2
STATE OF TENNESSEE )		1;12 pm
)	SS	
COUNTY OF KNOX )		
in and for said County and Sacquainted, or proved to me of acknowledged himself to be the SERVICE CORPORATION Tennessee general partners! Executive Vice President, being for the purposes therein contains such Executive Vice President.	State, JERRY L. In the basis of satisface Executive Vice F. a Partner of hip, the within naing authorized so to ined, by signing the of the Partner.	andersigned authority, a Notary Public BODIE, with whom I am personally factory evidence, and who, upon oath, President of WHITE REALTY AND DOWELL SPRINGS COMPANY, med bargainor, and that he as such do, executed the foregoing instrument name of the partnership by himself as
WITNESS my hand an	nd official seal of off	fice this <u>19</u> day of June, 2015.
My Commission Expires:	WALTER LAND CO. NO. NO. NO. NO. NO. NO. NO. NO. NO. N	Rublic State
I hereby swear or affirm	m that the actual cor	nsideration of this transfer is \$-0
		1011
	-6	27/1-6
	Affia	int /
Subscribed and sworn to before	re me this 19 day	of
	/	Vinley Sur-
My Commission Expires:	Nota Nota S/J// S	Public (
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Page: 2 0F 3	" din	iliani.
201506190069910		(27 %)

### **EXHIBIT "A"**

SITUATE in the Fifth (5th) Civil District of Knox County, Tennessee, within the 45th Ward of the City of Knoxville, Tennessee, being all of Lot 4R3 as shown on Final Plat of Dowell Springs Resubdivision of Lots 4R1, 4R2, 4R6, and J.P.E. Meadowgreen Way, dated April 27, 2015, filed for record as Instrument No. 201506190064904 in the Knox County Register of Deeds Office, to which plat specific reference is hereby made for a more particular description of said lot.

BEING a portion of the same property conveyed to Dowell Springs, L.L.C., a Tennessee limited liability company, by Warranty Deed from Irene M. Meadows (a/k/a Irene Wright Meadows), Widow, Individually and as sole beneficiary of the Estate of Leonel E. Meadows, dated August 20, 1998, filed for record in Warranty Book 2297, page 313 in the Knox County Register of Deeds Office. Dowell Springs, LLC, merged with and into Dowell Springs Company, a Tennessee general partnership, as evidenced by Certificate of Merger dated as of December 21, 1999, filed for record as Instrument No. 200001060001267 in the Knox County Register of Deeds Office.

ALSO BEING property conveyed to Dowell Springs Company, a Tennessee general partnership, by Quitclaim Deed from Home Federal Bank of Tennessee, dated as of June, 2015, filed for record as Instrument No. 20150619066 in the Knox County Register of Deeds Office.



PPLEMENTAL #1 August 26, 26180902

OWNER/RESPONSIBLE TAXPAYER:

RTG Dowell Springs, LLC 2200 Sutherland Avenue Knoxville, TN 37919 ATTN: GREG GHEEN Map 106D, Group A, Parcel 009.01 Map 106D, Group A, Parcel 009.02

Map 106D, Group A, Portion of Parcel 009.04

THIS INSTRUMENT PREPARED BY: TENNESSEE VALLEY TITLE INSURANCE CO. 800 South Gay Street, Suite 1700 Knoxville, TN 37929 File No. 141351 (RPM)

Sherry Witt Register of Deeds Knox County

# **QUITCLAIM DEED**

9 day of June, 2015, between EAST THIS INDENTURE made as of this TENNESSEE HEALTHREALTY, LLC, a Delaware limited liability company, First Party, and RTG DOWELL SPRINGS, LLC, a Tennessee limited liability company, Second Party:

### WITNESSETH:

THAT SAID FIRST PARTY, for and in consideration of the sum of ONE AND NO/100 (\$1.00) DOLLAR, and other good and valuable consideration, to it in hand paid by said Second Party, the receipt of which is hereby acknowledged, has bargained, sold, remised, released and QUITCLAIMED, and does by these presents bargain, sell, remise, release and QUITCLAIM unto Second Parys all of First Party's right, title and interest in and to the following described premises, to-wit:

### SEE EXHIBIT "A" ATTACHED HERETO AND MADE A PART HEREOF

With the hereditaments and appurtenances thereto appertaining, hereby releasing all claims therein to the said Second Party, its successors and assigns forever.

Whenever in this instrument a pronoun is used it shall be construed to represent either singular or plural, as the case may demand.

Knox County Page: 1 of 3 REC'D FOR REC 06/19/2015 11:55:37AM RECORD FEE: \$18.00

M. TAX: \$0.00 T. TAX: \$129.50

201506190069911

EAST TENNESSEE HEALTHREALTY, LLC. a Delaware limited liability company

> By: ProVision Health Partners, LLC

Manager

Mary Lou DuBois

Title: President

COUNTERSIGNED KNOX COUNTY PROPERTY ASSESSOR

JUN 1 9 2015

PHIL BALLA

August 25, 2015 1:12 pm

				1:12 pm
STATE OF TENNESSEE	)			
COLDITY OF VAION	)	SS		
COUNTY OF KNOX	)			
for said County and State, M. proved to me on the basis of s be the President of PROVITENNESSEE HEALTHREA named bargainor, and that s foregoing instrument for the	ARY Leatisfactors (SION ALTY, the as some purpose	OU DU ory evide HEALT LLC, a such Pre s therei	the undersigned authority, a Note BOIS, with whom I am personal ence, and who, upon oath, acknown I PARTNERS, LLC, the Manager limited liability comesident, being authorized so to an contained, by signing her name of East Tennessee HealthRealty, L	lly acquainted, or viedged herself to inager of EAST ipany, the within do, executed the e as President of
WITNESS my hand a	nd offic	ial seal	of office this 1844 day of June, 20	15.
9			Martina Stur	gell
My Commission Expires: 09	11120	la		5
2				
	8		¥	
				D.
l hereby swear or \$35,000.00.	affirm	n that	the actual consideration of	this transfer is
			/ 2/	
		(4	Afriant 7/	
Subscribed and sworn to be	fore me	this /	g May of 20	115
#		<u></u>		
	01-	diei	North Stander	~
My Commission Expires:	870	18	5 4 4 7	
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2000 30 (3);	0		William Kalania	
			Market State	
Page: 2 OF 3 20150619006991	1			
F0 1000 1300033 1	4			

### **EXHIBIT "A"**

SITUATE in the Fifth (5th) Civil District of Knox County, Tennessee, within the 45th Ward of the City of Knoxville, Tennessee, being all of Lot 4R3 as shown on Final Plat of Dowell Springs Resubdivision of Lots 4R1, 4R2, 4R6, and J.P.E. Meadowgreen Way, dated April 27, 2015, filed for record as Instrument No. 201506190069904 in the Knox County Register of Deeds Office, to which plat specific reference is hereby made for a more particular description of said lot.

BEING that property described in Declaration of Joint Permanent Easement made by Dowell Springs Company, a Tennessee general partnership, dated April 29, 2003, filed for record as Instrument No. 200305010099378 in the Knox County Register of Deeds Office.

SEE ALSO Termination of Declaration of Joint Permanent Easement made by and among Dowell Springs Company, Home Federal Bank of Tennessee, and East Tennessee HealthRealty, LLC, dated as of June 19, 2015, filed for record as Instrument No. 241506190061905 in the Knox County Register of Deeds Office.



SUPPLEMENT DOSO

August 20,60400902

OWNER/RESPONSIBLE TAXPAYER:

RTG Dowell Springs, LLC 2220 Sutherland Avenue Knoxville, TN 37919 ATTN: GREG GHEEN

Map 106D, Group A, Parcel 009.01 Map 106D, Group A, Parcel 009.02

Map 106D, Group A, Portion of Parcel 009.04

THIS INSTRUMENT PREPARED BY 2 pm / 06 DA 00904 TENNESSEE VALLEY TITLE INSURANCE CO.

800 South Gay Street, Suite 1700 Knoxville, TN 37929

File No. 141351 (RPM)

# **OUITCLAIM DEED**

THIS INDENTURE made as of this 19th day of June, 2015, between DOWELL SPRINGS COMPANY, a Tennessee general partnership, First Party, and RTG DOWELL SPRINGS, LLC, a Tennessee limited liability company, Second Party:

### WITNESSETH:

THAT SAID FIRST PARTY, for and in consideration of the sum of ONE AND NO/100 (\$1.00) DOLLAR, and other good and valuable consideration, to it in hand paid by said Second Party, the receipt of which is hereby acknowledged, has bargained, sold, remised, released and OUITCLAIMED, and does by these presents bargain, sell, remise, release and QUITCLAIM unto Second Party all of First Party's right, title and interest in and to the following described premises, to-wit:

# SEE EXHIBIT "A" ATTACHED HERETO AND MADE A PART HEREOF

With the hereditaments and appurtenances thereto appertaining, hereby releasing all claims therein to the said Second Party, its successors and assigns forever.

Whenever in this instrument a pronoun is used it shall be construed to represent either singular or plural, as the case may demand.

> COUNTERSIGNED KNOX COUNTY PROPERTY ASSESSOR

> > JUN 1 9 2015

DOWELL SPRINGS COMPANY, a Tennessee general partnership

By: White Realty and Service Corporation, a

Tennessee Corporation, Partner

Executive Vice President

Knox County Page: 1 of 3 REC'D FOR REC 06/19/2015 11:54:36AM

RECORD FEE: \$17.00 M. TAX: \$0.00 T. TAX: \$0.00

201506190069910

				August 25, 20
STATE OF TENNESSEE	)			1;12 pm
COUNTY OF KNOX	)	SS		
<u>-</u>	,			
in and for said County and acquainted, or proved to me acknowledged himself to be SERVICE CORPORATI Tennessee general partner Executive Vice President, be for the purposes therein consuch Executive Vice President	d State, e on the ethe Ex ON, a ership, peing auntained, ent of the	p JERRY I be basis of sacceutive Vice Partner of the within athorized so by signing the Partner.	c. BODIE, with waterisfactory evidence, be President of WHO DOWELL SPIN named bargainor, to do, executed the name of the par	and who, upon oath, IITE REALTY AND RINGS COMPANY, and that he as such foregoing instrument thership by himself as
WITNESS my hand	and of	ficial seal of	office this <u>/9</u> day	of June, 2015.
My Commission Expires:	8/5/	S S S S S S S S S S S S S S S S S S S	Mars Public S	Mu:
I hereby swear or af	firm tha	at the actual	consideration of this	s transfer is \$-0
			/a-P	4
		A	ffiant	
Subscribed and sworn to be	efore me	e this <u>/</u> 9 d	lay of Jame	, 2015.
My Commission Expires:	8/57	WBERLY S	lotary Public (MILLS)	~~~~
115 (C. C. C		A. C.	KNOX	Ti .
Page: 2 0F 3			Thuman way	
<b>~~2015061900699</b> 1	10		100 m	

August 25, 2015 1:12 pm

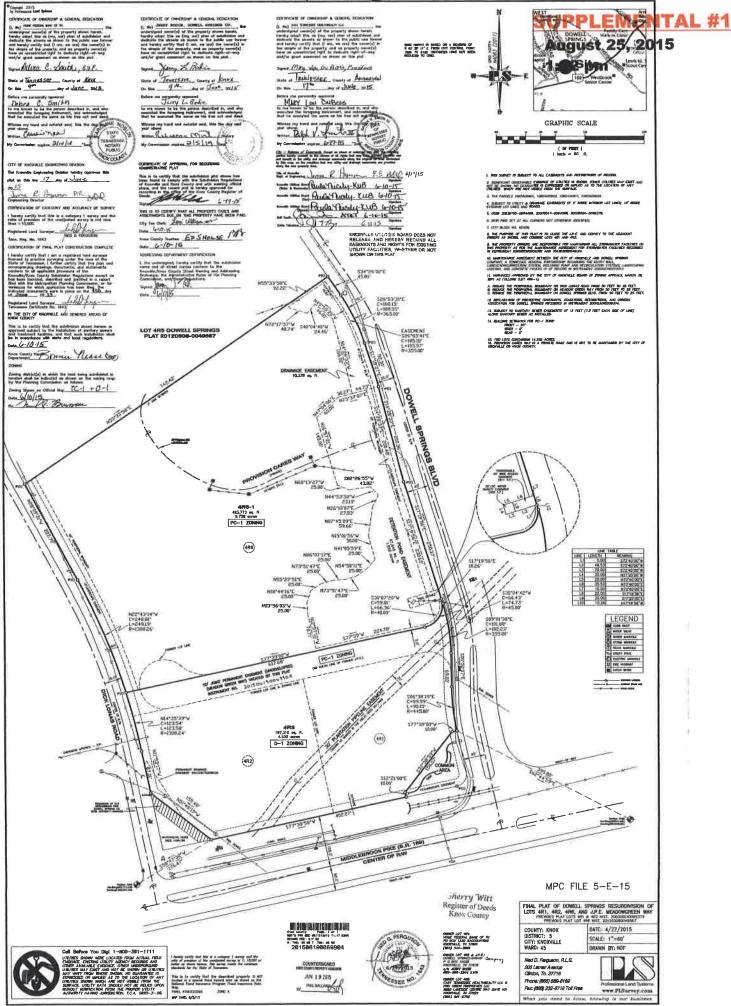
### **EXHIBIT "A"**

SITUATE in the Fifth (5th) Civil District of Knox County, Tennessee, within the 45th Ward of the City of Knoxville, Tennessee, being all of Lot 4R3 as shown on Final Plat of Dowell Springs Resubdivision of Lots 4R1, 4R2, 4R6, and J.P.E. Meadowgreen Way, dated April 27, 2015, filed for record as Instrument No. 201506190064904 in the Knox County Register of Deeds Office, to which plat specific reference is hereby made for a more particular description of said lot.

BEING a portion of the same property conveyed to Dowell Springs, L.L.C., a Tennessee limited liability company, by Warranty Deed from Irene M. Meadows (a/k/a Irene Wright Meadows), Widow, Individually and as sole beneficiary of the Estate of Leonel E. Meadows, dated August 20, 1998, filed for record in Warranty Book 2297, page 313 in the Knox County Register of Deeds Office. Dowell Springs, LLC, merged with and into Dowell Springs Company, a Tennessee general partnership, as evidenced by Certificate of Merger dated as of December 21, 1999, filed for record as Instrument No. 200001060001267 in the Knox County Register of Deeds Office.

ALSO BEING property conveyed to Dowell Springs Company, a Tennessee general partnership, by Quitclaim Deed from Home Federal Bank of Tennessee, dated as of June, 2015, filed for record as Instrument No. 2015061906 in the Knox County Register of Deeds Office.





To: AMSURG

August 25, 2015 1:12 pm

(Advertising) NOTIFICATION OF INTENT TO APPLY FOR (Ref No: 637645)

P.O.#:	NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED
	This is to provide official notice to the Health Services and Development A cy and all interested parties, in accordance with T.C. A. Sections 68-11-160
PUBLISHER'S AFFIDA	TO APPLY FOR A CENTICAL OF NEED  This is to provide official notice to the Health Services and Development Act y and all interested parties, in accordance with T.C.A. Sections 68-11-16 seq., and the Rules of the Health Services and Development Agency, that Endoscopy Center (an ambulatory surgical treatment center), owned by Endoscopy Center of Knoxville, L.P. (a limited partnership), and manage Amsurg Corp (a corporation), intends to file an application for a Certifica Need to relocate from 801 Welsgarber Road, Suite 100, Knoxville, TN 379 an unaddressed site in the northwest quadrant of the intersection of Michrook Pike (TN 169) and Dowell Springs Boulevard in Knoxville, a distance approximately 1.4 miles, and to reduce its procedure room complementicion (8) to six (5) rooms. The project cost for CON purposes is estimate \$14,000,000, of which approximately \$6,500,000 will be the actual capital. The balance consists of long-term lease payments which must be included CON rules.  This facility is currently licensed by the Brand for Uncersing Bealth.
State of Tennessee }	approximately 1.4 miles, and to reduce its procedure room complement eight (8) to six (6) rooms. The project cost for CON purposes is estimate \$14,000,000, of which approximately \$6,500,000 will be the actual capital of the approximately \$6,500,000 will be the actual capital of the project cost for CON purposes is estimated to the control of the con
County of Knox }  Before me, the undersigned, a Notary Public in and for said c	under CON rules.  This facility is currently licensed by the Board for Licensing Health Facilities as a single specialty ambulatory surgical treatment center limits endoscopy. The relocation will not change the facility's license classification will not change the facility's license classification.
Before me, the undersigned, a Notary Public in and for said c	The project does not contain major medical equipment or initiate or distinue any other health service; and it will not affect any facility's licensed complements.  The anticipated date of filing the application is on or before August 14,
Hurst first duly sworn, according to law, says that he/she is a Knoxville News-Sentinel, a daily newspaper published at Kno the advertisement of:	The contact person for the project is John Wellborn, who may be reach Development Support Group, 4219 Hillsboro Road, Suite 210, Nashville 37215; (615) 665-2022.  Upon written request by interested parties, a local Fact-Finding public her shall be conducted. Written requests for hearing should be sent to:  Tennessee Health Services and Development Agency Andrew Jackson Building, 9th Floor 502 Deaderick Street Nashville, TN 37243
(The Above-Reference	502 Deaderick Street Nashville, TN 37243  Pursuant to TCA Sec, 68-11-1607(c)(1): (A) any health care institution wis to oppose a Certificate of Need application must file a written objection the Health Services and Development Agency no later than fifteen (15)
of which the annexed is a copy, was published in said paper of 08/09/15 Sun	Pursuant to TCA Sec. 68-11-1607(c)(1): (A) any health care institution wis to oppose a Certificate of Need application must file a written objection the Health Services and Development Agency no later than fifteen (15) before the regularly scheduled Health Services and Development Agmeeting at which the application is originally scheduled, and (B) any person wishing to oppose the application must file written objection wit Health Services and Development Agency at or prior to the consideration the application by the Agency.
and that the statement of account herewith is correct to the bebeiref.	est of his/her knowledge, information, and
Subscribed and sworn to before me this day of _	August 20 15
ashly Breek	
Notary Public	
My commission expires	20





# **AFFIDAVIT**

STATE OFTENNESSEE
COUNTY OFDAVIDSON
JOHN WELLBORN, being first duly sworn, says that he is the lawful agent of the applicant
named in this application, that this project will be completed in accordance with the
application to the best of the agent's knowledge, that the agent has read the directions to this
application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-
1601, et seq., and that the responses to this application or any other questions deemed
appropriate by the Health Services and Development Agency are true and complete to the
best of the agent's knowledge.
SIGNATURE/TITLE CONSULTANT
Sworn to and subscribed before me this 14th day of Acquist, 2015 a Notary
Public in and for the County/State of <u>DAVIDSON</u>
NOTARY PUBLIC
My commission expires Joly 2, (Month/Day), 2018  (Month/Day)  (Year)  TENNESSEE NOTARY
E FRONCISCO CONTRACTOR OF THE PARTY OF THE P

### **AFFIDAVIT**

STATE OF TENNESSEE COUNTY OF DAVIDSON

NAME OF FACILITY: The Endoscopy Center (Knowille)

I, JOHN WELLBORN, after first being duly sworn, state under oath that I am the lawful agent of the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete to the best of my knowledge.

ONSULTANT

Sworn to and subscribed before me, a Notary Public, this the 25 day of 1witness my hand at office in the County of <u>DAVIDSON</u>, State of Tennessee.

My commission expires July

HF-0043

Revised 7/02

# Additional Information Supplemental #1 -Copy-

The Endoscopy Center of Knoxville

CN1508-030

August 31, 2015 12:19 pm

# DSG Development Support Group

August 28, 2015

Jeff Grimm, HSD Examiner Tennessee Health Services and Development Agency Andrew Jackson Building, 9<sup>th</sup> Floor 502 Deaderick Street Nashville, TN 37243

RE:

CON Application #1508-030s

Endoscopy Center of Knoxville

Dear Mr. Grimm:

This letter forwards a clarification of the first supplemental responses dated August 21. You requested further information documenting the Medicare or TDH Licensure acceptance of The Endoscopy Center's compliance with regulations in taking a time share approach to use of its space.

The reference to that is found in the Plan of Correction approved by the TDH, which is in the Attachments to the submitted application. To supplement that, attached is the TDH approval letter for that Plan of Correction. It appears that no Medicare waiver needed to be requested or granted, because TDH was performing inspections on Medicare's behalf.

Thank you for your assistance. We hope this provides the information needed to accept the application into the next review cycle. If more is needed please email or telephone me so that we can respond in time to be deemed complete.

Respectfully,

Well Com

John Wellborn

Consultant





August 31, 2015 12:19 pm

# STATE OF TENNESSEE DEPARTMENT OF HEALTH

OFFICE OF HEALTH LICENSURE AND REGULATION
EAST TENNESSEE REGION
5904 LYONS VIEW PIKE, BLDG. 1
KNOXVILLE, TENNESSEE 37919

July 09, 2012

Ms. Gale Mahan, RN, Administrator The Endoscopy Center 801 Weisgarber Rd Knoxville TN 37950

RE: 44C0001014

Dear Ms. Mahan:

The East Tennessee Region of Health Care Facilities conducted your annual recertification survey on April 3-4, 2012. An on-site revisit was conducted on May 3 and June 21, 2012. Based on the on-site revisit on May 3 and June 21, 2012 and review of your plan of correction, we are accepting your plan of correction and your facility is in compliance with all participation requirements as of May 19, 2012

If you have any questions, please contact the East Tennessee Regional Office by phone: 865-588-5656 or by fax: 865-594-5739.

Sincerely.

Karen B. Kirby, RN

Regional Administrator

East TN Health Care Facilities

Karen B Kirly Ko

KK: kg

TN000

August 31, 2015 12:19 pm

### **AFFIDAVIT**

STATE OF TENNESSEE
COUNTY OF DAVIDSON

NAME OF FACILITY:

I, JOHN WELLBORN, after first being duly sworn, state under oath that I am the lawful agent of the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete to the best of my knowledge.

The Endoscopy Center (Knoxville)

Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 31st day of 40gust, 2015, witness my hand at office in the County of DAVIDSON, State of Tennessee.

NOTARY PUBLIC

My commission expires July 2.

HF-0043

Revised 7/02